Yes, I want to help provide quality healthcare for future generations.

Community Memorial Hospital Foundation

"To encourage and inspire charitable giving that will enhance the family-centered healthcare services and education provided by the Community Memorial Hospital District and its associated entities."

Donor Information (please print or type)

Name _____

Billing address _____

City, ST Zip Code _____

Phone 1 | Phone 2 _____

Fax | Email _____

My tax-deductible gift is to be used for: ☐ Current Needs ☐ Best CMH Use

☐ In Memory or ☐ In Honor of _____

Tax-Deductible Pledge Information

I (we) pledge a total of $_____ to be paid: ☐now ☐monthly ☐quarterly ☐yearly.

I (we) plan to make this contribution in the form of: ☐cash ☐check ☐credit card ☐other.

Credit card type | Exp. date _____

Credit card number _____

Authorized signature _____

☐Please contact me about making a legacy gift through my will and estate plans.

Acknowledgement Information

Please use the following name(s) in all acknowledgements: _____

☐I (we) wish to have our gift remain anonymous.

Signature(s) _____ **Date** _____

_____

Make checks, and all other gifts, payable to:

CMH Foundation, Attn: Laura Lea Fossenbarger, PO Box N, Syracuse, NE 68446