

ALL CHILDREN'S HOSPITAL FOUNDATION DONATION FORM

Please print and complete this form to make a gift to All Children's Hospital Foundation

Name _____

Company (if corporate gift) _____

Address _____

City _____ State _____ Zip _____

Daytime phone _____ Email _____

I would like to support All Children's with a gift of \$ _____

Check Enclosed

American Express Card

Visa

Mastercard

Discover Card

Card Number _____ Expiration date ____/____

Signature _____

(Signature required for all credit card charges)

I would like my gift to be used: (check one)

where the need is greatest

Pediatric Medical/Surgical Program

Pediatric Research

Charity Care

TRIBUTE GIFT – I would like my gift to be in honor or in memory of a special person:

My gift is in honor of / in memory of _____

Please notify:

Name _____

Address _____

City _____ State _____ Zip Code _____

I would like to receive a gift envelope to help make future gifts.

I would like to receive information on volunteer opportunities.

I would like to receive information on how to include All Children's Hospital Foundation in my will or estate plan.

Please mail this form with your donation to:

All Children's Hospital Foundation
P.O. Box 3142, St. Petersburg, FL 33731-3142
For questions, please call 727-767-4199