DONOR INFORMATION

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr.

Name: _____

Address: _____

City: _____ Telephone: _____

State: _____ Zip: _____

Preferred Email: _____

DONOR OPTION

I wish to give:

❑ $1,000 ❑ $750 ❑ $500 ❑ $250 ❑ $125

❑ Other: $_____

❑ Check Enclosed *(Please make checks payable to Riverview Health Care Foundation)*

❑ Visa ❑ Mastercard

Card Number: _____

3-digit code: _____ Expiration Date (Month/Year): ____ / ____

Name *(as it appears on card)*: _____

Billing Address: _____

Card Holder Signature: _____

Riverview

HEALTH CARE FOUNDATION

DESIGNATE YOUR GIFT

Please select a fund where you would like your gift to go. If no fund is specified, your gift will be designated to the Area of Greatest Health and Wellness Needs.

❑ Greatest Health and Wellness Needs

❑ Riverview Hospital Association Health and Wellness Needs

❑ Community Health and Wellness Needs

❑ Pediatric Needs

❑ Cancer Patient Fund

❑ Riverview Community Dental Clinic

❑ UW Cancer Center at Riverview Hospital

❑ Women's Health Needs

❑ Riverview Family Clinics

❑ Other: _____

Riverview Health Care Foundation is a 501(c)(3) charitable organization and, as such, your contributions are tax deductible to the fullest extent provided by law. 100% of your contribution will go to the fund(s) you designate.