Donation | Gift Form

I | We support Aspirus Divine Savior Hospital & Clinics with our total commitment of $ _____

I | We plan to pay this pledge according to the following schedule:

☐ Payment enclosed in full

☐ Please send a reminder for full payment in: (month | year) _____

☐ Please accept my payment on an annual basis and send a reminder each year.
I will contribute $ _____ each year for ___ years for a total contribution of $_____.

Send donations to:

Aspirus Divine Savior Hospital & Clinics, ATTN: Community Relations Department PO Box 387, Portage, WI 53901

Recognition:

Donations will be recognized on our Annual Gift and Cumulative Gift recognition walls at Aspirus Divine Savior Hospital & Clinics where applicable.

Name as you would like to be recognized:

_____

☐ I | We wish this gift to be anonymous. Do not recognize me | us publicly.

Payment:

☐ Check enclosed. (Please make payable to Aspirus Divine Savior Hospital & Clinics.)

☐ Please change my credit card. ☐ Visa ☐ Mastercard ☐ American Express ☐ Discover

Card # _____ Exp. Date _____ Security Code _____

Name _____

Cardholder Address _____

Donor Email _____ Donor Phone _____

Special Notes:

Questions about donating? Call us at 608.745.5605

Thank you. Your gift will change lives.

ASPIRUS® HEALTH

CLEAR FORM

All gifts are tax deductible to the full extent provided by law. Please consult your tax advisor.