DONATION FORM

Name(s) ____

Organization Name (If applicable) ____

Mailing Address____

City, State, ZIP Code____

Home/Office Phone________________________________Cell___________________________________

Email____

For recognition purposes, please indicate exactly how you would like your name or company name to appear:

____

For Corporations, please email your logo in EPS and JPEG format to Donations@Holy-Cross.com.

I (We) wish to make a gift of $____

Total number of installments ______________________ over a period of _______________________ year(s).

Starting date________/_______/_________

The gift will be paid as follows:

☐ Payment in full ☐ Semi-annually ☐ Monthly

☐ Annually ☐ Quarterly ☐ Bi-Weekly

Payment Method:

☐ Check ☐ Credit Card ☐ Other______________________

Tribute:

Select Type: ☐ In Honor of ☐ In Memory of Name (s)________________________________

☐ Mail a letter on my behalf.

Mailing Address____

City, State, ZIP Code ____

Phone ________________________________ Email ____

Additional Gift Information____

____

A COPY OF THE OFFICIAL REGISTRATION AND FINANCIAL INFORMATION MAY BE OBTAINED FROM THE DIVISON OF CONSUMER SERVICES BY CALLING TOLL-FREE (800-435-7352) WITHIN THE STATE. REGISTRATION DOES NOT IMPLY ENDORSEMENT. REGISTRATION NUMBER CH2746. EIN: 59-0791028.

I (We) would like for the gift be designated to:

☐ Area of Greatest Need/Unrestricted

☐ Capital Improvements & Expansion

☐ Medical Equipment

☐ Jim Moran Heart & Vascular Center

☐ Michael and Dianne Bienes Comprehensive Cancer Center

☐ Dorothy Mangurian Comprehensive Women's Center

☐ Phil Smith Neuroscience Institute

☐ Orthopedic Institute

☐ Catherine Yardley Comprehensive Pulmonary Center

☐ Employee Hardship Assistance (Catherine McAuley Fund)

☐ Cardiac Cath Labs

☐ Partners in Breast Health

☐ Inpatient Rehabilitation

☐ Outpatient Rehabilitation

☐ Research Institutes

☐ Education & Training for Clinical and Support Staff

☐ Family Health Center

☐ Employee Appreciation & Engagement

☐ Institute for Nursing Excellence

☐ Other______________________________________

Signature____Date_________/________/__________

Your signature above indicated that you have reviewed and agree with the information you have provided on this form.

Your gift is tax-deductible to the fullest extent allowed by law.

☐ I/We wish to remain anonymous and elect not to be recognized.

☐ I/We have already named Holy Cross Health as a beneficiary in my/our will.

☐ I/We would like more information on estate and gift planning.

Please make checks payable to: **Holy Cross Hospital, Inc.**

Please send completed form to:

Holy Cross Health
Office of Development
4725 North Federal Highway, Fort Lauderdale, FL 33308
954-542-8562
Donations@Holy-Cross.com
www.HolyCrossDonations.com

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