

## Donate Now

### Contact Information

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

### Donation Amount

I would like to donate \$ \_\_\_\_\_ as a...

- Recurring Gift
  - Monthly
  - Quarterly
  - Annually
  - Please send me a reminder for recurring gifts
- One-time gift

### Donation Designation

- Unrestricted, please apply this gift where the need is greatest
- Hospital project of the year
- Health Education
- Hospital upgrades and renovations
- Benevolent Fund
- Medical Staff Recruitment
- Other

If other please specify: \_\_\_\_\_

- Please disperse my donation between programs designated above as follows:  
\_\_\_\_\_

- I wish for my gift to remain confidential

**Major Gift or Pledge**

- I would like to make a major gift or pledge to the above designated project in the amount of \$ \_\_\_\_\_ to be paid as...
  - One payment
  - Pledge of payments over a period of
    - One year
    - Two years
    - Three years
- I would like to make a major gift or pledge to the hospital and would like to discuss the designated project and amount with a Foundation representative

**Legacy Giving / Estate Planning**

- I have included Walla Walla General Hospital in my estate plan and thus am eligible for membership in the Isaac and Maggie Dunlap Society. Please send me information about the society's activities and an invitation to the annual Members Reception.
- I would like to attend the next Estate Planning Seminar (free to all participants) to learn more about options in my estate planning and legacy giving.
- I would like to visit with a WWGH Foundation staff member for additional information about estate planning and legacy giving to benefit the hospital.

**Optional—I would like my gift to be:**

In memory of: \_\_\_\_\_

In honor of: \_\_\_\_\_

In celebration of: \_\_\_\_\_

**Address Acknowledgement to:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

**Payment Information**

- My check is enclosed.
- Please charge my credit card:

Card Type

- MasterCard
- Visa
- American Express
- Discover

Name as it appears on card \_\_\_\_\_

Card Number \_\_\_\_\_

Security Code \_\_\_\_\_ Expiration month/year \_\_\_\_\_ / \_\_\_\_\_

Total charge, as detailed above \$ \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Print this form and mail to:**

Walla Walla General Hospital Foundation  
PO Box 1398  
Walla Walla WA 99362

Please call WWGH Foundation at 509-527-8303 if you have any questions regarding the use of this form or about any aspect of the fund raising program for the hospital.

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_