Beth Israel Deaconess Hospital
Needham

Donation Form

Donor Information (please print or type)

Name:					
Address:					
City:		State:		ZIP Code:	
Telephone:					
E-Mail:					

Gift Information

I (we) would like to support Beth Israel Deaconess Medical Center–Needham with a gift of

☐ $25 ☐ $50 ☐ $100 ☐ Other $_____

I (we) would like to designate my (our) gift to the following fund:

☐ Annual Fund ☐ Other:_____

Payment Information

☐ My (our) check is enclosed. **Please note: checks must be payable to Beth Israel Deaconess Medical Center–Needham.**

☐ I (we) wish to charge my (our) gift to: ☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

Credit card number:		Exp. Date:	
Exact Name on Card:			
Authorized signature:			
Security Code:			

Tribute Information

My (our) gift is ☐ In Honor of ☐ In Memory of ☐ In Celebration of

Name(s):	

Please send notification to: *(The amount of your gift will not be forwarded with the notification.)*

Name:					
Address:					
City:		State:		ZIP Code:	

Please return your gift and this form to:

Office of Development
Beth Israel Deaconess Medical Center–Needham
330 Brookline Avenue (BR)
Boston, MA 02215
617-667-7330 / 617-667-7340 (fax)

☐ Enclosed is a matching gift form from: _____

☐ I have included BIDMC–Needham in my will or trust.

☐ I would like more information about including BIDMC-Needham in my will or trust.

☐ Send me information about gifts to BIDMC–Needham that provide lifetime income to me.

Thank you for your generous support!