

# Montefiore

## DONATION FORM

Yes I/ we would like to make a donation to support Montefiore Medical Center

### Donor Information:

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

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

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

Phone No: \_\_\_\_\_ Email Address: \_\_\_\_\_

### Donation Designation:

Unrestricted to the Medical Center

In support of: \_\_\_\_\_

### Payment Information:

I/we will make a donation of: \$ \_\_\_\_\_

Please charge to my credit card:  Visa  MasterCard  American Express  Discover

Account Number: \_\_\_\_\_ Exp. Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Enclosed is my check (*payable to Montefiore Medical Center*)

### Honorary and Memorial Gifts:

This gift is being made in  Honor /  Memory of: \_\_\_\_\_

Please notify the following person regarding this honorary/memorial gift:

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

**Thank you for your support!**

*Please mail this donation form with your contribution to:*

Montefiore Medical Center

Office of Development

111 East 210<sup>th</sup> Street

Bronx, NY 10467

Phone (718) 920-6656 ■ Fax: (718) 547-9274