



PERSHING
Health System
FOUNDATION

Yes, I would like to support the **Pershing Health System Foundation**.

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Recognition Preference:

Please list my name as: _____

I prefer to remain anonymous

My Gift:

One-Time Gift \$ _____

Memorial Gift \$ _____

Honor Gift \$ _____

Pledge Gift \$ _____

Pledge Terms:

1 year 2 years 3 years

Payment Schedule:

One-Time Monthly Quarterly

Direct my gift to (optional):

Payment Information:

Card #: _____

Exp Date: _____ ZIP: _____

Name on Card: _____

Tribute Notification (optional):

Name: _____

Address: _____

Comments: _____
