give

I/We would like to make Baystate Health Foundation my/our charity of choice.

DONOR INFORMATION *(please print)*

Title(s) and Name(s) _____

Email _____ Phone _____

Business Name (if applicable) _____

Address _____

City _____ State _____ Zip _____

Donor Signature *(required on all gifts)* _____ **Date** _____

Gift Amount $ _____ **Monthly Option (please charge $_____each month)**

For recognition purposes, I/we would like to be listed as:

_____

❑ **Anonymous**

Cumulative giving of $1,000 or more to our annual fund within one calendar year earns you recognition in our President's Society.

I/WE WOULD LIKE MY GIFT TO SUPPORT *(check one)*

- ❑ Where the need is greatest
- ❑ Baystate Children's Hospital
- ❑ Baystate Franklin Medical Center
- ❑ Baystate Home Health
- ❑ Baystate Hospice
- ❑ Baystate Mary Lane Outpatient Center
- ❑ Baystate Medical Center
- ❑ Baystate Noble Hospital
- ❑ Baystate Wing Hospital
- ❑ Baystate Heart & Vascular Program
- ❑ Baystate Neurosciences Program
- ❑ Baystate Regional Cancer Program
- ❑ Other _____

TRIBUTE GIFTS

I/We would like my/our gift to be in memory or in honor of a loved one, friend, Baystate Health care provider or colleague *(please circle "in memory" or "in honor").*

Honoree Name _____

If you would like us to notify the family or honoree (gift amount will not be disclosed), please complete the following:

Name _____

Address _____ City _____ State _____ Zip _____

PAYMENT METHOD

❑ **Cash/Check** *Please make your check payable to:* **Baystate Health Foundation**
Mailing Address: **280 Chestnut Street | Springfield, MA 01199**

❑ **Credit Card** ❑ Visa ❑ Mastercard ❑ AmEx ❑ Discover

Name (*as it appears on card*)

Credit Card Number _____ Expiration Date ___ ___ / ___ ___

To make a gift online or to learn about other ways to make a gift, please visit baystatehealth.org/bhf

Baystate Health Foundation's non-profit tax ID is 04-3549011 and gifts are tax-deductible as allowed by law.

CS1611948