Medina Hospital Foundation

Yes, I/we want to help Medina Hospital. Enclosed is my gift of:

( ) $1,000 * ( ) $750 ( ) $500 ( ) $_____

* Gifts of $1,000 or more are recognized in the Partners for Life giving society.

Name _____

Address _____

City _____ **State** _____ **Zip** _____

___ **Enclosed is my / our check for $_____**

___ Please send reminders for payment:

- ❑ One annual payment of $_____ (before December 31)
- ❑ Two payments (2 @ $_____) (June, December)
- ❑ Four payments (4 @ $_____) (March, June, October, December)

___ Please charge my contribution to the following credit card:

❑ MasterCard ❑ Visa ❑ Discover

Account#_____

Exp Date _____ Security Code _____(found on back of card)

Name on Card _____

❑ One annual payment of $_____ (___ Now, or _____, 2014)
(specific date)

❑ _____ payments (@ $_____) Dates: _____ _____ _____ _____

Signature:_____

___ I/we wish to make a gift of appreciated stock. (Please contact the Foundation Office for transfer information at 330-721-5940 or fuerstr@ccf.org)

___ Please update me on the latest Medina Hospital activities and health news electronically. My email address is:

_____

___ I am interested in receiving information about a specific Medina Hospital Department

_____

___ My employer will match my donation. Enclosed is my company's matching gift form. My company's name is:

_____

___ Please provide me with information on:

- ❑ Making a gift that will return income to me for life.
- ❑ Including Medina Hospital in my estate plans.

___ I/we wish to designate our gift for _____

Signature _____ Date _____

Medina Hospital
a Cleveland Clinic hospital