AdventistHealth | Rideout Foundation

PLEDGE FORM

DONOR INFORMATION (Please print):

Name: _____

Address: _____

City/State/ZIP: _____

Phone: _____

E-Mail: _____

PLEDGE INFORMATION:

Gift Amount: $_____ **Contribute:** __Monthly __Quarterly __Annually

Duration: _____ (number of Months/Quarters/Years until pledge is met)

Designation: __ Area of greatest need __Cancer Center __Family Birth Center/NICU

__Heart & Vascular __Emergency Dept. __Rideout Regional Medical Center

__Other_____

Acknowledgment: __I (we) wish to remain completely anonymous

__Please list our name as _____

Tribute: This gift is in honor, memory, or recognition of_____

Signature(s): _____ Date: _____

_____ Date: _____
