*Please print this form, fill in and mail to the address below:*

**Give the Gift of Health**

# by supporting

**PLEDGE FORM**

# 1314 East Walnut Street Washington, Indiana 47501

**(812) 254-2760, ext. 1126**

**Daviess Community Hospital Foundation**

Whether small or large, your gift will make a difference in the lives

of those receiving services through Daviess Community Hospital.

##  DONOR INFORMATION:

Name: Check here if you wish to remain ANONYMOUS.

Mailing Address:

City:

State:

Zip:

Phone Number:

Email:

##  GIFT PLEDGE AMOUNT: $

Please use where there is “Greatest Need” Designate for:

##  PAYMENT METHOD:

This pledge will be paid over a period of years, beginning with my first gift on .

Please send reminders: annually on

semi-annually on

quarterly on

monthly on

Please make checks payable to: Daviess Community Hospital Foundation.

Credit Card: All major credit cards accepted.

Credit Card Number: Exp Date:

Cardholder Name:

Signature:

 **MY GIFT IS (***please print***):**

In Memory of:

In Honor of:

##  PLEASE SEND ACKNOWLEDGEMENT TO:

Name:

Mailing Address:

City:

State:

Zip:

 **ABOUT DAVIESS COMMUNITY HOSPITAL FOUNDATION:**

Daviess Community Hospital Foundation is a not-for-profit 501( c)(3) organization. All gifts are tax deductible as allowed by law. Please consult your financial advisor.

**“Community is our middle name.”**