Community Pledge Form

HC HOLY CROSS HEALTH FOUNDATION

INFORMATION

☐ Personal ☐ Company

☐ Mr. ☐ Ms. ☐ Mrs. ☐ Dr. _____

Company _____

Address_____

City _____ State _____ Zip _____

Preferred Phone _____ Email _____

METHOD OF PAYMENT

☐ AS A ONE-TIME PAYMENT   ☐ IN INSTALLMENTS OVER _____ YEARS *(maximum 5 years)*

I will contribute a total of $_____ to be paid by

☐ **Cash/check enclosed** (made payable to the Holy Cross Health Foundation)

☐ **Invoice me**   ☐ One time   ☐ Quarterly   ☐ Annually

    Billing address if different from above _____

☐ **Credit Card**   ☐ VISA   ☐ MASTERCARD   ☐ AMERICAN EXPRESS   ☐ DISCOVER

    Card # _____ Expiration Date _____

    Billing address if different from above _____

GIVING DESIGNATION

Areas of Greatest Need

☐ **Unrestricted Giving to Holy Cross Health**

☐ **New Outpatient Ambulatory Cancer Center**

Other Important Areas of Need

☐ Community Health and Well-Being

☐ Holy Cross Germantown Hospital President's Fund

☐ Kevin J. Sexton Fund to Increase Access and Improve Community Health

☐ Holy Cross Hospital Labor and Delivery Renovation

☐ Military and Veterans Health Program (MILVET)

☐ Mission Services

☐ Neonatal Intensive Care Unit (NICU)

☐ Neuroscience Program

☐ Nursing Excellence

SIGNATURE

SIGN_____DATE_____

RECOGNITION & TRIBUTE

☐ Yes, I authorize public acknowledgment of my gift in press or publications as

    follows _____

☐ No, I wish to remain anonymous.

This gift is   ☐ In honor of   ☐ In memory of   ☐ With gratitude to a caregiver

Please recognize this gift in the name of_____

☐ I am interested in naming opportunities.

THANK YOU

Save your completed form and email it to
Eric.Miller@HolyCrossHealth.org

Holy Cross Health Foundation
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Phone: 301-754-7101
HolyCrossHealth.org/Foundation