



Charitable Gift Form

Please complete and return this form with your donation to:
Rogers Memorial Hospital Foundation
34700 Valley Road
Oconomowoc, WI 53066

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

<p>PLEASE ACCEPT MY/OUR GIFT/PLEDGE IN THE AMOUNT OF:</p> <p><input type="checkbox"/> \$1,000 <input type="checkbox"/> \$500 <input type="checkbox"/> \$250 <input type="checkbox"/> \$100 <input type="checkbox"/> \$50 <input type="checkbox"/> Other \$ _____</p> <p><input type="checkbox"/> This is a one-time gift. <input type="checkbox"/> This is a recurring gift. <input type="checkbox"/> Monthly <input type="checkbox"/> Biannually <input type="checkbox"/> Quarterly <input type="checkbox"/> Annually for _____ years</p> <p><input type="checkbox"/> In honor of: _____ <input type="checkbox"/> In memory of: _____ <input type="checkbox"/> I wish to remain anonymous.</p>	<p>DONATION CATEGORY</p> <p><input type="checkbox"/> Angel Fund <input type="checkbox"/> Capital Campaign <input type="checkbox"/> Endowment Fund <input type="checkbox"/> General Fund <input type="checkbox"/> Patient Care Grants <input type="checkbox"/> Spiritual Care Program <input type="checkbox"/> Where it is most needed</p>
<p><input type="checkbox"/> I would like to learn more about the Rogers Legacy Society or naming opportunities.</p>	

I PREFER TO MAKE PAYMENT BY:

- Check—Made payable to *Rogers Foundation*
 - My check is enclosed. Please bill me.
- Credit Card—Please charge my credit card.
 - Visa MasterCard

Card Number

_____/_____
Expiration Date

Signature

All gifts are tax-deductible as provided by law. If you have questions or would like more information, please contact the Foundation Office at 262-646-1646.