

Donate Card
9X3.75
Prints front only



**Sustaining
McGehee
Hospital
and
McGehee
Family Clinic**

Please print clearly and mail back in the reply envelope.

Name (First & Last) _____

Address _____

City _____ State _____ Zip _____

Phone (home) _____ Phone (cell) _____

Email _____

I would like to be a sustaining supporter with a gift of \$ _____ **Date** _____

monthly annually

Sustaining MONTHLY Giving Levels \$12.50 \$25 \$50 \$100

Sustaining ANNUAL Giving Levels \$150 \$300 \$600 \$1,200

Payment Information

Check enclosed: payable to McGehee Hospital Foundation

Bank draft: Bank _____ bank routing # _____ account # _____

Charge my credit card: Name on card _____

Visa MasterCard Discover American Express

Account Number _____ 3 digit security code _____

Expires: Month _____ Year _____

Signature (as it appears on card) _____ Date _____