

# Sisters of Charity Health System Donation Form

## Donor Information

This gift is from an:  Individual  Organization  Do not include me on the donor honor roll  
Organization: \_\_\_\_\_ Title (Mr./Mrs./Ms./Dr.): \_\_\_\_\_  
First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_  
Address Line 1: \_\_\_\_\_  
Address Line 2: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Email/Phone (optional): \_\_\_\_\_

## Gift Information

This is a:  One-time gift  Recurring gift (*Please fill in the shaded recurring gift payment schedule area*)

Frequency: <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly	Payment Date: <input type="checkbox"/> 1 <sup>st</sup> <input type="checkbox"/> 15 <sup>th</sup> day of the month
Start date: _____	Pick <input type="checkbox"/> End Date: _____
one: <input type="checkbox"/> Continue payments until I instruct otherwise	

Amount:  \$25  \$50  \$100  Other: \_\_\_\_\_

Payment Method:  I am enclosing a check or money order payable to Sisters of Charity Health System  
 Charge my credit card  Visa  MasterCard  Discover  American Express  
Cardholder Name: \_\_\_\_\_  
Card Number: \_\_\_\_\_ Exp: \_\_\_\_\_  
Signature: \_\_\_\_\_ Security Code: \_\_\_\_\_

## Designation

*Please indicate one or more ministries. To split a gift between multiple ministries, indicate the amount or percent for each ministry.*

<input type="checkbox"/> St. Vincent Charity Community Health Center	<input type="checkbox"/> Joseph & Mary's Home
<input type="checkbox"/> St. Vincent Charity Health Campus	<input type="checkbox"/> Light of Hearts Villa
<input type="checkbox"/> Building Healthy Communities	<input type="checkbox"/> Regina Health Center
<input type="checkbox"/> Early Childhood Resource Center	<input type="checkbox"/> South Carolina Center for Fathers and Families
<input type="checkbox"/> Healthy Learners	

## Tribute (optional)

This gift is  In honor of  In memory of \_\_\_\_\_  
Party to notify of tribute gift: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

*Thank you for your support of the ministries of the Sisters of Charity Health System!*

**Mail this form along with your payment to:**  
Sisters of Charity Health System, Fund Development Department  
2475 East 22<sup>nd</sup> Street, Cleveland, OH, 44115



**SISTERS of CHARITY**  
HEALTH SYSTEM

*A Ministry of the Sisters of Charity of St. Augustine*