Sisters of Charity Health System Donation Form

Donor Information

This gift is from an: ❑ Individual ❑ Organization ❑ I want this gift to remain anonymous

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: ❑ Monthly ❑ Quarterly Payment Date: ❑ 1st ❑ 15th day of the month

Start date: _____ *Pick one:* ❑ End Date: _____

❑ 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.

____ St. Vincent Charity Medical Center

____ Mercy Medical Center

____ Building Healthy Communities

____ Early Childhood Resource Center

____ Healthy Learners

____ Joseph's Home

____ Light of Hearts Villa

____ Regina Health Center

____ South Carolina Center for Fathers and Families

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 22nd Street, Cleveland, OH, 44115

SISTERS of CHARITY
HEALTH SYSTEM
A Ministry of the Sisters of Charity of St. Augustine