

Mail/Fax Donation Form

Enclosed is my contribution of \$ _____ **(Please make checks payable to SJPHS Foundations)**

You may select the hospital, entity and/or area that you wish your gift to be directed. **If no hospital, entity or area is selected, gift will go toward area of greatest need.**

Please direct my gift to the following hospital or entity (optional):

- | | |
|---|---|
| <input type="checkbox"/> Brighton Center for Recovery | <input type="checkbox"/> St. John River District Hospital |
| <input type="checkbox"/> Providence Hospital | <input type="checkbox"/> Community Health |
| <input type="checkbox"/> Providence Park Hospital (Novi) | <input type="checkbox"/> Eastwood Clinics |
| <input type="checkbox"/> St. John Hospital and Medical Center | <input type="checkbox"/> Holley Institute |
| <input type="checkbox"/> St. John Macomb-Oakland Hospital | <input type="checkbox"/> Hospice |

Please direct my gift to the following area (optional):

- | | |
|---|--|
| <input type="checkbox"/> Behavioral Medicine | <input type="checkbox"/> Kids on the Go |
| <input type="checkbox"/> Brighton Children's Addiction Prevention Program | <input type="checkbox"/> Neurosciences |
| <input type="checkbox"/> Brighton Patient Extended Care Fund | <input type="checkbox"/> Palliative Care |
| <input type="checkbox"/> Cancer Program (specify Pediatric or Adult program in "Other" box below) | <input type="checkbox"/> Pediatrics |
| <input type="checkbox"/> Heart Program | <input type="checkbox"/> Women's Health Services |
| <input type="checkbox"/> Infant Mortality Program | <input type="checkbox"/> Area of Greatest Need |
| <input type="checkbox"/> Other: Restrict my gift to the following department or purpose (provide as much detail as possible): | |

Company Name: _____

Your Name: _____

Address: _____

City/State: _____ Zip Code _____

Email: _____

Phone: _____

Please charge my credit card: VISA MasterCard Discover American Express Check one: Corporate Card Personal Card

Account #: _____ Exp. Date: _____

Name of Card Holder: _____

Signature: _____ Date: _____

This gift is:

In memory of: _____

In tribute to: _____

Please notify (name): _____

Relationship (i.e., spouse, child, etc.) _____

Address: _____

City/State: _____ Zip Code _____

St. John Providence Health System Foundations coordinates private support for St. John Providence Health System member institutions and their programs. Your contribution may be tax-deductible. Consult with your tax advisor. For more information on giving opportunities, please call 313-343-7480.

Please print form and mail or fax.

Mail to: St. John Providence Health System Foundations or Fax to: 313-343-7487
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