ORLANDO HEALTH
Foundation

MEMORIAL GIFT FORM

Donor Name: (as you would like it to appear in print) _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Email Address: _____

My gift is in memory of:

(Name) Mr. Mrs. Ms. _____

Please notify the following individual(s) that this gift has been made (without mention of gift amount):

Name:_____
(as you would like it to appear in print)

Address: _____

City: _____ State: _____ Zip: _____

Relationship to deceased: ❑ Spouse ❑ Mother/Father ❑ Daughter /Son ❑ Niece /Nephew Other: _____

For the amount of:

❑ $1,000 ❑ $500 ❑ $250 ❑ $100 ❑ $50 ❑ $25 ❑ Other: $_____

❑ Check here if your gift is eligible to be matched by your employer. I have enclosed my matching gift form.

Employer Name_____

I would like my gifts used for:

- ❑ Orlando Health's most immediate needs
- ❑ Arnold Palmer Medical Center
  - ❑ Arnold Palmer Hospital for Children
  - ❑ Winnie Palmer Hospital for Women & Babies
  - ❑ Howard Phillips Center for Children & Families
- ❑ UF Health Cancer Center – Orlando Health
- ❑ Orlando Regional Medical Center
  - ❑ Level One Trauma Center
  - ❑ Cardiac Care
- ❑ Dr. P. Phillips Hospital
  - ❑ Cynthia C. & William E. Perry Pavilion at Dr. P. Phillips Hospital
- ❑ Hubbard House
- ❑ Health Central Hospital
- ❑ South Seminole Hospital
- ❑ Other: _____

Payment Type: ❑ Check ❑ Credit Card

❑ Cardholder information same as donor name above

Cardholder Name: _____

Cardholder Billing Address:_____

City: _____ State: _____ Zip:_____

Credit Card Number: _____ Expiration Date: _____ CSC: _____

I hereby authorize Orlando Health Foundation to process payment for the above donation by method of the charge information given.

Cardholder Signature: _____ Date: _____

Please mail to: Orlando Health Foundation • 3160 Southgate Commerce Blvd., Suite 50, Orlando, FL 32806

or Fax to: 407.425.8545 • Phone: 407.841.5194

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