ORLANDO HEALTH® | *Foundation*

DONATION FORM

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❑ $500 ❑ $250 ❑ $100 ❑ $50 ❑ $25 ❑ Other $_____

I WISH TO DIRECT MY GIFT TO: ❑ Orlando Health (Area of Greatest Need)

❑ Orlando Health Orlando Regional Medical Center (ORMC)
❑ Orlando Health Arnold Palmer Hospital for Children
❑ Orlando Health Winnie Palmer Hospital for Women & Babies
❑ Orlando Health Cancer Institute
❑ Orlando Health Dr. P. Phillips Hospital
❑ Orlando Health St. Cloud Hospital
❑ Bayfront Health St. Petersburg
❑ The Howard Phillips Center for Children & Families
❑ Orlando Health - Health Central Hospital
❑ Orlando Health Horizon West Hospital
❑ Orlando Health South Lake Hospital
❑ Orlando Health South Seminole Hospital
❑ Cynthia C. & William E. Perry Pavilion

❑ Please provide me with more information on a provision in my will or estate plan for Orlando Health Foundation.

PAYMENT & CONTACT INFORMATION: ❑ MasterCard ❑ Visa ❑ AMEX ❑ Discover ❑ Check

Please print your name as you wish to be recognized _____
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Check should be made payable to the *Orlando Health Foundation* or make your secure donation online at OrlandoHealth.com/Give. We greatly appreciate your support! Thank you.

I would like this gift to be in ❑ honor ❑ memory of _____
Please notify the following person of my gift: -OR- ❑ Check here if you wish to remain anonymous
Name _____ Relationship (to person being honored) _____
Address _____ City _____ State _____ Zip _____
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I hereby authorize Orlando Health Foundation to process payment for the above donation by method of the charge information given.

Signature:_____ **Date:** _____

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

Phone: (321) 841-5194 Fax: (407) 425-8545

1739-102612b 04/21