



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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