

DONATION FORM

I WOULD LIKE TO MAKE A LASTING IMPACT IN THE AMOUNT OF:

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

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

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

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 _____

Cardholder Name _____ Signature _____

Credit Card Number _____ Exp. Date _____ CVV _____

Address _____ City _____ State _____ Zip _____

Phone _____ Email _____

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 _____

Phone _____ Email _____

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

CONTRIBUTIONS TO THE FOUNDATION ARE DEDUCTIBLE FOR INCOME TAX PURPOSES TO THE EXTENT ALLOWED BY LAW. THE FOUNDATION RECOMMENDS THAT YOU CONSULT WITH YOUR TAX ADVISOR CONCERNING ALLOWABLE DEDUCTIONS. A COPY OF THE OFFICIAL REGISTRATION AND FINANCIAL INFORMATION MAY BE OBTAINED FROM THE DIVISION OF CONSUMER SERVICES BY CALLING, TOLL FREE, 800.435.7352 WITHIN THE STATE OF FLORIDA. REGISTRATION DOES NOT IMPLY ENDORSEMENT, APPROVAL OR RECOMMENDATION BY THE STATE. THE FOUNDATION IS A REGISTERED CHARITABLE ORGANIZATION (CH577).