Print Form

Mercy
HEALTH FOUNDATION

DONOR INFORMATION

Title *(Dr.,Mr.,Mrs.,Ms.):*_____ Name *(First, Last Name)*: _____

Company Name *(if applicable)*: _____

Street Address: _____

City, State, Zip: _____

Telephone: _____ E-mail: _____

AMOUNT

The Mercy Society: *Recognizes individuals who provide gifts of $1,000 or more annually.*

☐ $10,000 ☐ $5,000 ☐ $2,500 ☐ $1,500 ☐ $1,000

Partners:

☐ $750 ☐ $250 ☐ $125 ☐ $100 ☐ $_____

ADDITIONAL INFORMATION

Corporate: ☐ *This donation is on behalf of a company.*

Anonymous: ☐ *I prefer to make this donation anonymously.*

TRIBUTE GIFT INFORMATION (if applicable)

☐ This gift is in honor of: _____

☐ This gift is in memory of: _____

Where would you like the acknowledgement for your honor or memory gift to be mailed?

Title *(Dr,Mr.,Mrs.,Ms.):*_____ Name *(First, Last Name)*: _____

Street Address: _____

City, State, Zip: _____

PAYMENT INFORMATION

☐ **Check Enclosed** ☐ **Charge the Credit Card Below**

Cardholder's Name: _____

Credit Card Number: _____

Card Type: ☐ Visa ☐ Mastercard ☐ American Express ☐ Discover

Card Expiration Date *(MM/YY)*:_____ Card Security Code:_____

If your credit card mailing address is different from above, please complete the following:

Street Address: _____

City, State, Zip: _____

SIGNATURE: _____ Date: _____

Please return this form via mail to: **Mercy Health Foundation, 301 St. Paul Place, Baltimore, MD 21202** or via **fax 410-659-1194**.