Donation Form

cascade HEALTH FOUNDATION

Today's Date:_____

First Name:_____ Last Name:_____

Address:_____ City:_____ State:_____ Zip:_____

Main Ph:_____ ☐ Hm ☐ Cell Work Ph:_____

Other Ph:_____ OK to leave detailed message? ☐ Yes ☐ No

Email:_____

Enclosed is my tax-deductible gift to the Cascade Health Foundation's Wind Beneath Our Wings memorial gift program at the following level:

☐ Gold Feather ($25,000 and above): $_____

☐ Silver Feather ($10,000 to $24,999): $_____

☐ Bronze Feather ($1,000 to $9,999): $_____

☐ Make my gift a multi-year pledge of $_____/year for the next: ☐ 3 ☐ 5 ☐ Other:_____years.

Please include the following on my feather:

☐ In Honor of ☐ In Loving Memory of ☐ In Memory of ☐ In Memory of ☐ (name only)

Name to be engraved:_____

☐ Please send acknowledgement of this memorial gift to:

Name(s):_____

Address:_____ City:_____ State:_____ Zip:_____

Email:_____

☐ I wish to remain anonymous in donor recognition materials.

Method of payment: ☐ Check (enclosed) ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Card number:_____ CVV:_____ Exp.:_____ Zip:_____

Name on card:_____ Signature:_____

Thank you for your gift! You will receive a donation receipt in the mail for tax purposes.