White Plains Hospital

Donation Form

Please print this page, fill out the form below and mail, along with your tax deductible donation, to:

White Plains Hospital Foundation, 41 East Post Road, White Plains, NY 10601

DONOR INFORMATION

First and Last Name: _____

Spouse First and Last Name: _____

Street Address: _____

City, State Zip: _____

Email: _____

Phone: _____ (Circle: Home/ Cell/ Business)

GIFT INFORMATION

1) **Gift Amount** $_____

2) **Gift Purpose** □ The enclosed is an **unrestricted gift** to White Plains Hospital

□ The enclosed is a **restricted gift** to the following program:

□ _____

3) **Gift Type** □ CHECK (Please make checks payable to **White Plains Hospital Foundation**)

□ CREDIT CARD Please charge my credit card:

Name on Card: _____

Account number: _____ Exp date: _____ CSC#: _____

Authorized signature: _____Date:_____

HONORARY/MEMORIAL GIFT

If your gift is in honor or in memory of a special person, please fill out the additional information below.
Please note that due to processing costs, we regret that we cannot accept honor/memorial gifts less than $25 dollars.

This gift is made in honor of: _____

This gift is made in memory of: _____

Please notify the following individual of my donation:

Name _____

Address _____

City _____ State _____ Zip _____

Thank you for supporting White Plains Hospital