

FOUNDATIONS Mail/Fax Donation Form

Enclosed is my contribution of \$ _____ **(Please make checks payable to Ascension St. John and Providence Foundations)** Date: _____

Please direct my gift to the following hospital or entity: **(If no selection is made, gift will support needs that benefit patient care outcomes.)**

- | | | |
|--|---|---|
| <input type="checkbox"/> Ascension Brighton Center for Recovery | <input type="checkbox"/> Ascension St. John Hospital | <input type="checkbox"/> Holley Institute |
| <input type="checkbox"/> Ascension Macomb-Oakland Hospital | <input type="checkbox"/> Ascension River District Hospital | <input type="checkbox"/> Hospice (Support Fund) |
| <input type="checkbox"/> Ascension Providence Hospital, Novi | <input type="checkbox"/> Ascension Michigan Community Health | |
| <input type="checkbox"/> Ascension Providence Hospital, Southfield | <input type="checkbox"/> Ascension Eastwood Behavioral Health | |

Please direct my gift to the following area: **(If no selection is made, gift will support needs that benefit patient care outcomes.)**

- | | |
|--|--|
| <input type="checkbox"/> Behavioral Medicine | <input type="checkbox"/> Neurosciences |
| <input type="checkbox"/> Brighton Patient Extended Care Fund | <input type="checkbox"/> Pediatrics |
| <input type="checkbox"/> Cancer program (specify pediatric or adult program in "Other" box below) | <input type="checkbox"/> Pet Therapy (indicate hospital above) |
| <input type="checkbox"/> Heart program | <input type="checkbox"/> Women's Health Services |
| <input type="checkbox"/> Infant Mortality Program | |
| <input type="checkbox"/> Other: Restrict my gift to the following department or purpose (provide details in box below) | |

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Company Name: _____

Your Name: _____

Address: _____

City/State: _____ Zip Code _____

Email: _____

Phone: _____

Please charge my credit card: VISA MasterCard Discover American Express Check one: Corporate Card Personal Card

Account # _____ Security Code: _____ Exp. Date: _____

Name of Card Holder: _____ Billing Address: _____

Signature: _____ City/State/Zip: _____

This gift is a tribute:

In memory of: _____

In honor/support of: _____

Send tribute card to (indicate spouse, parent, etc.): _____

Name: _____

Address: _____

City/State: _____ Zip Code _____

Ascension St. John Foundation and Ascension Providence Foundation coordinate support for Ascension Michigan hospitals, entities and programs. Your contribution may be tax-deductible. Consult with your tax advisor. For more information on giving opportunities, please call 313-343-7480.

Please print form and mail or fax.

Mail to: Ascension St. John and Providence Foundations or Fax to: 313-343-7487
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 Grosse Pointe Woods, Michigan 48236