MARTHA'S VINEYARD HOSPITAL | WINDEMERE Nursing & Rehabilitation Center

DONATION FORM

YOUR INFORMATION

Your Name _____ Phone (_____) _____ Email _____

PRIMARY MAILING ADDRESS

Address _____

_____

City _____

State _____

Zip Code _____

ISLAND MAILING ADDRESS

Address _____

_____

City _____

State _____

Zip Code _____

YOUR DONATION

Amount $ _____

☐ *This is a recurring gift (This gift amount will be automatically charged on the 15th of each month until directed otherwise. You can cancel at any time.)*

Names _____

_____

For recognition purposes, print name(s) as you wish them to appear.

☐ I would prefer to receive the MVH Annual Report and Newsletter via email

☐ I would prefer my gift remain anonymous

PLEASE APPLY MY DONATION TO

☐ Martha's Vineyard Hospital

☐ Windemere Nursing & Rehabilitation Center

MY GIFT IS

☐ in memory of ☐ in honor of

Tribute Name _____

Your Relationship to Tribute _____

Who Should We Notify? *(Provide Name and Address)*

_____

_____

_____

PAYMENT INFORMATION

☐ Enclosed is a check for the above amount.

☐ Visa ☐ Mastercard ☐ Discover ☐ Amex

Card Number _____

Exp. Date ____ /_____ CVC _____

Name on Card _____

Signature _____

Date of Signature _____

MATCHING GIFTS

This gift will be matched by:
(Company or Organization Name and Address)

_____

_____

_____

What prompted your gift today?

_____

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