



GIFT FORM

*The People You Know...
The Professionals You Trust*

Mr./Ms./Mrs./Miss Name(s): _____

Phone(s): _____ Email: _____

Address: _____

I am/We are pleased to support the mission of WCA Hospital to improve the health and well being of all those served with compassion, dedication, and a commitment to quality, while maintaining economic viability and a vision for the 21st century.

Enclosed is a gift of \$_____. Please make check/money order payable to: *WCA Hospital*.

Please bill my credit card in the amount of \$_____. Credit cards gifts can also be taken over the phone by calling (716) 664-8423.

MasterCard/Visa/Discover Card Holder: _____ Card #: _____ Exp. Date: _____ Sec. Code: _____

Signature: _____ Date: _____

These gifts are tax-deductible, subject to IRS guidelines. You will receive a formal gift receipt.

Please direct this gift to:

Meet the greatest needs of WCA Hospital and those we serve. Other (please specify) _____

THANK YOU!

Please return completed Gift Form to:

**WCA Office of Development
PO Box 840, 207 Foote Avenue
Jamestown, NY 14702-0840
(716) 664-8423
development@wcahospital.org**

TRIBUTE GIFT

In Memory of _____ In Honor of _____

Please send gift acknowledgement to: Name(s) _____

Address _____