CARROLL HOSPITAL
Foundation

CARE BRAVELY

Check Donation Form

Donor's Information

First Name: _____ Last Name: _____

Address: _____

_____

City: _____ State: _____ Zip Code: _____

Day Phone: _____ Evening Phone: _____

Cell Phone: _____ E-Mail: _____

Donation Information

I would like to designate my gift to Carroll Hospital to the following area(s):

- ☐ Wherever the need is greatest
- ☐ Cardiovascular & Stroke
- ☐ Center for Breast Health
- ☐ Education and Training
- ☐ Patient Assistance Fund
- ☐ Surgical Services
- ☐ Tevis Center for Wellness
- ☐ William E. Kahlert Regional Cancer Center
- ☐ Other, please specify: _____

Gift Information

Are you a current donor? ☐ Yes ☐ No

Gift Type: I am pleased to make a ... ☐ New gift ☐ New payment on an existing pledge

Contribution Amount: $ _____

Anonymous Gift? ☐ Yes ☐ No

Name as you would like it to appear in recognition materials: _____

_____

Gift as a Tribute

My gift is in memory of: _____

My gift is in honor of: _____

Please send notification of my gift to: (name and address) _____

_____

Continued on next page

How did you hear about Giving Opportunity?

☐ I Received a Letter

☐ Advertisement

☐ Employee

☐ Friend/Family Member

☐ Obituary

☐ Special Event

☐ Web Browsing

☐ Other, please specify: _____

Planned Giving

☐ Please provide me with information about wills and estate planning

☐ I have a question, please contact me

I've already included Carroll Hospital in my estate planning through:

☐ My will

☐ A trust arrangement

☐ Other: (please specify)_____

_____

Thank You

Thank you for your donation to Carroll Hospital, a LifeBridge Health center.

Please mail this form along with your check or money order to:
Carroll Hospital Foundation
Attn: Foundation Office
200 Memorial Avenue
Westminster, MD 21157
410-871-6200