Donor Information: *(Please print or type)*

Name: _____

Department: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Work: _____ Email: _____

Pledge Information:

I/we pledge ☐ $500 ☐ $750 ☐ $1,000 ☐ Other _____ to support the **Vision 2025 Physician Giving Campaign**

I/we will pay the balance due over *(check one)* ☐ 1 ☐ 2 ☐ 3 year(s).

Please remind me: ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually ☐ Other _____

Total pledge: _____ Paid now: _____ Balance due: _____

For recognition purposes, please print my/our name(s) as: _____

This gift is in memory of: _____ In honor of: _____

Donation Designation:

I/we would like my (our) donation to be used for the following: _____

Payment Information:

Paid by:

☐ Cash

☐ Check *(Please make your check payable to Children's Hospital & Medical Center Foundation)*

☐ Payroll Deduction

☐ Stock Transfer (Please send transfer information)

☐ Credit Card (We accept Visa, Master Card, American Express, Discover)

Card #: _____ Expiration date: _____

Name on card: _____

I would like receipts for my contributions: ☐ e-mailed ☐ mailed ☐ no receipt (outside of year-end statement)

Signature (required): _____ **Date:** _____

CHILDREN'S HOSPITAL & MEDICAL CENTER FOUNDATION | 8404 INDIAN HILLS DRIVE, SUITE 650 | OMAHA NE 68114 | 402.955.6859