Plumas HEALTH CARE FOUNDATION

Donor

Donor Name _____

Mailing Address _____ **City** _____ **State** _____ **Zip** _____

Telephone _____ **Email** _____

Gift:

I would like to make a contribution of $_____to Plumas Health Care Foundation.

This contribution will be allocated to (*please check one*):

☐ The area of greatest need

or

☐ The new hospital building

Recognition:

☐ This is a Memorial / Tribute gift honoring_____

Please notify this person of this gift

Name_____

Mailing Address_____

City_____State_____Zip_____

or

☐ I would like this gift to be recognized in the name (s) of:_____

or

☐ I prefer to remain anonymous

Payment Method:

☐ Cash

☐ Check (make payable to Plumas Health Care Foundation)

☐ Credit Card (Type):_____

Name on card:_____

Card Number:_____

Expiration Date:_____

Signature:_____