



DONATION FORM

Contact Information

<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr. <input type="checkbox"/> Other _____	(First Name)
	(Last Name)
Street Address	
City ST ZIP Code	
Home Phone	
Work Phone	
E-Mail Address	

Donation Amount

(Please check one)

- | | |
|-------------------------------|--|
| <input type="checkbox"/> \$10 | <input type="checkbox"/> \$40 |
| <input type="checkbox"/> \$20 | <input type="checkbox"/> \$50 |
| <input type="checkbox"/> \$30 | <input type="checkbox"/> _____ Other (please fill in blank with donation amount) |

Please Select Payment Method

(*Required Fields)

*(Check One) Check VISA MasterCard American Express Discover

(Please fill out below completely if payment is NOT by check.)

*Credit Card #: _____ *Exp. Date
(mo./yr.): _____

Card ID (3 or 4 digit # on back of card): _____

*Billing address if different from above:

Agreement and Signature

By submitting this donation form, I affirm that the facts set forth in it are true and complete. I agree to submit the above donation using the payment method I herein specified.

Name (printed)	
Signature	
Date	

SEND DONATIONS TO:

The Foundation for East Orange General Hospital
300 Central Avenue
East Orange, NJ 07018
-or-
Fax: 973.266.4570

Thank you for being so thoughtful. Your gift to the Foundation for East Orange General Hospital is truly appreciated.