

# Grateful Patient Donation Form



401 West Campbell Road | Richardson, Texas 75080

Send your contribution payable to Richardson Regional Medical Center Foundation along with this form or use our secure online donation form at [RichardsonRegional.com](http://RichardsonRegional.com).

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Daytime Phone \_\_\_\_\_

Evening Phone \_\_\_\_\_

E-mail \_\_\_\_\_

Please indicate the area(s) you wish to support and choose the gift amount below.

- |  |  |
|--|--|
| <input type="checkbox"/> Area of greatest need   | <input type="checkbox"/> Oncology Services |
| <input type="checkbox"/> Cardiovascular Services | <input type="checkbox"/> Neurosciences     |
| <input type="checkbox"/> Women's Services        | <input type="checkbox"/> Newborn Services  |
| <input type="checkbox"/> Education               | <input type="checkbox"/> Research          |

- |                                |                                  |                                      |                                |                                |
|--------------------------------|----------------------------------|--------------------------------------|--------------------------------|--------------------------------|
| <input type="checkbox"/> \$25  | <input type="checkbox"/> \$50    | <input type="checkbox"/> \$75        | <input type="checkbox"/> \$100 | <input type="checkbox"/> \$250 |
| <input type="checkbox"/> \$500 | <input type="checkbox"/> \$1,000 | <input type="checkbox"/> Other _____ |                                |                                |

- My check is enclosed.  
 I prefer to use my credit card.

Type of card \_\_\_\_\_ Expiration date \_\_\_\_\_

Card number \_\_\_\_\_

Name on card \_\_\_\_\_

Signature \_\_\_\_\_

Please acknowledge this gift to:

Name \_\_\_\_\_

Department \_\_\_\_\_

*Your gift is tax deductible in accordance with provisions of the Internal Revenue Service Code.*