GUNDERSEN
MEDICAL FOUNDATION

Gift Form

Donor Information (please print):

Donor name(s): _____

Address: _____

City, State, Zip: _____ Phone: _____

E-mail: _____

Please use my gift, in the amount of (circle one):

$500 $200 $100 $50 $25 Other $_____, to support programs in:

_____ Medical Education
_____ Medical Research
_____ Community Health Outreach
_____ Specific Designation _____
_____ Priority Programs/Where Needed Most
_____ Children's Miracle Network Hospital®

Gift Details:

☐ In Memory of: _____
☐ In Honor of: _____
☐ For the Occasion of: _____

Please notify the following of this gift:

Name (s): _____
Relationship to person being honored/remembered: _____
Address: _____
City, State & Zip: _____

Payment Information:

☐ Check: Please make your tax deductible contribution payable to:

Gundersen Medical Foundation
1900 South Avenue
La Crosse, WI 54601

☐ Charge my gift to: MasterCard _____ Visa _____ Discover _____ American Express _____

Card # _____ Exp. Date _____

☐ Bank Draft Deduction: Please attach a voided check for bank draft deduction. *for recurring donations only*

Thank you for your gift to Gundersen Medical Foundation. Please contact the Philanthropy Office at (608) 775-6600 or gmf@gundersenhealth.org if you have questions.