

Gift Information

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Please use my gift, in the amount of (circle one): \$25 Other \$_____, to support programs in: \$500 \$200 \$100 \$50 _____ Medical/Health Education _____ Priority Programs/Where Needed Most _____ Children's Miracle Network Hospital[®] _____ Medical Research ____ Specific Designation _____ **Payment Information:** Check: Please make your tax deductible contribution payable to: **Gundersen Medical Foundation** 1836 South Avenue La Crosse, WI 54601 Charge my gift to: MasterCard ____ Visa ___ Discover ____ American Express____ Card # _____ Exp. Date _____

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Comments:_____

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