

## **Memorial Donation Form**

## In Loving Memory of:

(Print full name)				
Enclosed is my gift of:  \$\int \\$25 \int \\$50 \int \\$75 \int \\$100 \int \\$  Given By:				
			Name:	
			Address:	
City:	_ State:			
Zip code:				
Please send acknowled	lgement to:			
Name:				
Address:				
Address:	State:			
Address:	_ State:			
Address:  City:  Zip code:	_ State:			
Address:  City:  Zip code:	_ State:			
Address:  City:  Zip code:	_ State:			

OUR COMMUNITY'S HEROE Work Hero

A Memorial donation to the Clarion Hospital Foundation is a special way of expressing your love and is also a way to pay tribute to a person who is no longer with us.

The Clarion Hospital Foundation is happy to help you honor those you love and hold dear to your heart. Contributions of any size are graciously accepted and may be designated for a particular need at Clarion Hospital. Please know that your memorial gift will help us continue to provide top-quality, local healthcare for years to come.

To honor the memory of a loved one, please print this form and complete the information.

Mail the completed form with a check or complete the credit card payment form if you choose to pay with a credit card.

Make checks payable to: Clarion Hospital Foundation

Mail completed form and memorial gift to:

Clarion Hospital Foundation 1 Hospital Drive Clarion, PA 16214

When a memorial gift is received by the Clarion Hospital Foundation, an acknowledgement letter will be sent to you (for tax purposes) and to the family of the person being honored.



## Credit Card Payment Form

Name:	
Addres	ss:
Phone	Email:
Gift An	nount:
	☐ Check Payable to Clarion Hospital Foundation
	☐ Credit Card: Visa / MasterCard / American Express / Discover
	Account Number:
	Expiration Date: Security Code:
	Name On Card:
	Signature:
Mail co	mpleted form to:
	Clarion Hospital Foundation 1 Hospital Drive, Clarion, PA 16214
	Gifts can also be made online at youry clarion beenital org