I WOULD LIKE TO DONATE *(check one)*:
❑ $500 ❑ $250 ❑ $150 ❑ $75 ❑ $25 ❑ Other _____

Grateful Patient Program

This Gift Is: ❑ In Memory of ❑ In Honor of ❑ Other
Name:_____
Please Notify:_____

PAYMENT OPTIONS:
❑ I've enclosed a check payable to Woodland Healthcare Foundation.
❑ I authorize Woodland Healthcare Foundation to debit the following credit card:
Card No: _____ Exp date:_____
Name on card: _____Signature:_____

DONATION OPTIONS:
❑ One time donation ❑ Repeating donation, deducted monthly
Start date: _____ # of Months: _____
Donated By:
Name:_____
Address: _____
City / State / Zip: _____
Phone: _____ Email:_____

The amount of your gift is confidential. Your gift is tax deductible.
There is no greater gift than one that brings health and healing to others.

WOODLAND HEALTHCARE FOUNDATION