

DONATION FORM

Today's Date: _____

Your 100% tax-deductible donation to New York Downtown Hospital will support its life-saving work as the only hospital in Lower Manhattan. Thank you!

Yes! I wish to make a 100% tax-deductible donation in the amount of:

- \$75 \$100 \$250 \$500 \$1,000
 \$1,500 \$2,500 \$5,000 \$10,000 Other \$ _____

My company has a matching gift program: Form enclosed to be sent

I wish to make this gift anonymously.

Please designate my gift: In Honor of _____ In Memory of _____

Person to Notify: _____

Address: _____

Please include the amount of my gift in the notification.

SPECIAL INSTRUCTIONS: _____

Donor Name: (Dr. / Mr. / Mrs. / Ms.) _____

Individual Company Foundation Organization

Preferred address: Home Business

Name: _____ Title/Dept: _____

Company: _____

Address: _____ City: _____ State: _____ Zip: _____

Daytime Phone: _____ Email: _____

Your information will not be sold or exchanged.

Please check where appropriate:

Enclosed please find my check made out to **NEW YORK DOWNTOWN HOSPITAL**

Charge my credit card \$ _____ American Express MasterCard VISA

Credit Card #: _____ Expiration Date: ____ / ____

Card Holder Name: _____ Signature: _____

FAX THIS FORM TO: (212) 801-1711 or

MAIL TO: Development Office, New York Downtown Hospital, 170 William Street, New York, NY 10038

Please contact Development Office at (212) 801-1700 for any inquiries regarding this donation.

Thank you for supporting Lower Manhattan's only hospital!