

# St♥Mary's FOUNDATION

**Please designate my gift for:**

- |   |   |
|---|---|
| <input type="checkbox"/> Hospital Greatest Need       | <input type="checkbox"/> Pastoral Care Fund                   |
| <input type="checkbox"/> Adult Day Health Center      | <input type="checkbox"/> Ronald McDonald Family Room Fund     |
| <input type="checkbox"/> Cardiac Care                 | <input type="checkbox"/> St. Mary's Care Center Greatest Need |
| <input type="checkbox"/> Emergency Department Fund    | <input type="checkbox"/> St. Mary's Renal Center Fund         |
| <input type="checkbox"/> Family Care Suites Fund      | <input type="checkbox"/> Other _____                          |
| <input type="checkbox"/> Neonatal Intensive Care Fund |   |

**I support St. Mary's Foundation with my gift of:**

\$25     \$50     \$100     \$250     \$500     \$1,000     \$Other

Title(s) \_\_\_\_\_

Name(s) \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Phone \_\_\_\_\_ EMail \_\_\_\_\_

Donor Recognition Name(s) \_\_\_\_\_

I wish to remain anonymous

**Optional:**     In Memory of    (or)     In Living Tribute to:

Name \_\_\_\_\_

I'd like an acknowledgment of my gift sent to:

Name \_\_\_\_\_ Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Bill Visa/Mastercard

Check enclosed

Card # \_\_\_\_\_

Exp. Date \_\_\_\_\_ CVV2 Code \_\_\_\_\_ (3 digit # on back of card)

Signature \_\_\_\_\_

- I have included St. Mary's in my will.  
 I want to know how I can receive lifetime income,  
while reducing taxes, through a planned gift.  
 I was born at St. Mary's

**Mail completed form to:**

St. Mary's Foundation  
700 South Park Street  
Madison, WI 53715  
Phone: 608-258-5600  
Email: [stmarysfoundation@ssmhc.com](mailto:stmarysfoundation@ssmhc.com)