Evergreen Health
FOUNDATION

Gift Agreement

Please accept my gift of $ _____

Please use this gift for:

❍ Unrestricted: where needed most ❍ Service area or program: _____

Personal Information

First Name* Middle Name Last Name*

Email* Telephone (XXX-XXX-XXXX)*

Street 1* Street 2

City* State* Zip or Postal Code

Country if other than U.S.

❍ I am giving jointly with _____

Payment Method

❍ My one-time gift is enclosed (payable to Evergreen Health Foundation)

❍ Charge my entire gift to my credit card

Name (as it appears on your credit card)*

Credit Card Number*

Month/Year Expiration Date* Security Code (3 digit code Visa, MC, Discover; 4 digit code AMEX)

Signature*

❍ My gift is in honor of:

❍ My gift is in memory of:

❍ I would like acknowledgement of this gift sent to the address above

❍ I would not like gift acknowledgement sent

First Name* Middle Name Last Name*

Street 1* Street 2

City* State* Zip or Postal Code

* Required

Please mail this form to: Evergreen Health Foundation, PO Box 1106, Buffalo, NY 14201
or foundation@evergreenhs.org (credit card payments only)