

Stillwater
Medical Center DONATION FORM
FOUNDATION

Name(s) _____

Address _____

City _____ ST _____ ZIP _____

Phone _____ E-mail _____

I wish my gift to remain anonymous.

 My check for \$_____, payable to SMC Foundation, is enclosed

Please Charge \$_____ to my credit card:

Card # _____ Exp _____

Security Code _____ Signature _____

Monthly Giving:

Please charge the gift as listed above on (circle one):

Day 1 of each month

Day 16 of each month

Your first gift will be made today and then on the date selected of each following month.

You may cancel or change your gift at any time by contacting the Foundation.

I would like to designate this gift for:

Cancer Center ICU

Cardiovascular Care ER

Other: _____

*If no designation is made,
your gift will be considered unrestricted.*

This gift is: In Memory of In Honor of

Celebrating the Birth of

Please send an acknowledgement to:

Name _____

Address _____

City _____ St _____ Zip _____

Return by fax to 405-742-5768

Return by Mail to:

SMC Foundation

PO Box 2408 • Stillwater, OK 74076