Stillwater Medical FOUNDATION DONATION FORM

Name(s) _____

Address _____

City_____ ST _____ ZIP _____

Phone _____ E-mail _____

❑ I wish for 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 _____

I would like to designate this gift for:

❑ Women's Health Center

❑ Surgery Expansion ❑ ER

❑ COVID-19 Relief Fund

❑ Other:

_____

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

This gift is: ❑ In Memory of ❑ In Honor of

_____

Please send an acknowledgement to:

Name _____

Address_____

City_____ St _____ Zip _____

❑ I would like to know more about monthly giving.

❑ I would like information about leaving a gift in my will.

Return by Mail to:
Stillwater Medical Foundation
PO Box 2408 • Stillwater, OK 74076

Fax to: 405-742-5768