

Stillwater Medical  
**FOUNDATION**  
DONATION FORM

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

Address \_\_\_\_\_

City \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

Phone \_\_\_\_\_ E-mail \_\_\_\_\_

I wish for my gift to remain anonymous

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 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:

NICU - Neonatal ICU

Women's Health Center

Surgery  ER

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 \_\_\_\_\_

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 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