

MY PLEDGE

Please print your name as you would like it to appear for recognition purposes:

Address

City

State

Zip

Phone (Home)

Phone (Office)

Fax

Email

As a measure of my commitment, it is my intent to contribute to the Memorial Health Care System Foundation as follows:

\$ _____ to be paid over a period of _____ years.

Please send pledge reminders on these dates: _____

Please charge \$ _____ to my: (circle one) Visa MasterCard Discover AmEx
On a: (circle one) Monthly basis Quarterly basis Annual basis

Credit Card Number

Expiration Date

Name on Card

I would like to designate this gift to the following area: _____

I wish to remain anonymous.

Signature

Date

For further information, please contact us at 423-495-4438.

Please make checks payable to:
Memorial Health Care System Foundation
2525 de Sales Avenue
Chattanooga, TN 37404

† CATHOLIC HEALTH
INITIATIVES

Memorial Health Care System
Foundation