Divine Savior
HEALTHCARE

Donation/Gift Form

I/We support Divine Savior Healthcare with our total commitment of $_____

I/We plan to pay this pledge according to the following schedule:

- ☐ Payment enclosed in full.
- ☐ Please send a reminder for full payment in: (month/year) _____
- ☐ Please accept my payment on an annual basis and send a reminder each year. I will contribute $_____ each year for years for a total contribution of $_____

Send donations to: Divine Savior Healthcare, P.O. Box 387, Portage, WI 53901

Recognition

Donations will be recognized on our Annual Gift and Cumulative Gift recognition walls at Divine Savior Healthcare where applicable.

Name as you would like to be recognized (limit 30 characters including spaces):

_____

- ☐ I/We wish this gift to be anonymous. Do not recognize me/us publicly.

Payment:

- ☐ Check enclosed. (Please make payable to Divine Savior Healthcare.)
- ☐ Please charge my credit card. ☐ Visa ☐ Mastercard ☐ American Express ☐ Discover

Card # _____ Exp. Date _____ Security Code _____

Name _____

Cardholder Address _____

Donor Email _____Donor Phone _____

Special Notes:

Questions about donating? Call us at 608-745-5605.

Thank you. Your gift will change lives.

All gifts are tax deductible to the full extent provided by law. Please consult your tax advisor.

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