

GIVING FORM

Please print out this form and return it, along with your donation to: Valley Health Systems, Development Dept., 20 Hospital Drive, Holyoke MA 01040

GIFT TYPE.						
> I wish to make a on	e-time donation of: 🗆 \$2	5 □\$50 □\$100 [□\$250 □\$500	□\$1,00	0 Other \$	
With installments m	edge of \$ to be paid nade (select one): \(\subseteq \text{N}\) onthly gift at any time by calling 4	lonthly □Quarte			□3 years	
GIFT INFORMATION:						
Please designate my/our gift	to: \square Where it is needed	d most \Box Other:				
This gift is in Honor of:						
This gift is in Memory of:						
Please Notify:						
Name		Address		City	State	Zip
DONOR INFORMATION:						
First Name:	lame: Last Name:					
Street Address:		City:	State:		Zip:	
Home Phone:your gift.	Business/Cell Phon	e:	*Please provide your	phone num	າber in case we have a q	uestion about
E-mail:						
For recognition purposes, I/v	we would like to be listed a	s:				
☐ I/we would like to remain	anonymous					
PAYMENT INFORMATION: 20 Hospital Drive, Holyoke, N		make checks payable to	Valley Health Sys	tems and	l mail to: Developm	ent Office,
Donations by credit card can or call the Development Office		/www.holyokehealth.co	om/Give-Now/Do	nate/		

THANK YOU FOR YOUR DONATION!

All gifts to Valley Health Systems, the parent company of Holyoke Medical Center, are tax-deductible as allowed by law.

Unless otherwise requested, your gift will be acknowledged in our annual Donor Report.

An acknowledgment will be mailed to you upon receipt of your gift.

Questions? Please call 413-534-2579 or email development@holyokehealth.com