

Please send this form to:
Rutland Health Foundation
433 West Street
Rutland VT 05701
802.775.7932 FAX

Please print clearly.

Donation Type (Please check one option)

- I want to make a single gift of \$ _____
- I want to make a monthly gift of \$ _____ totaling \$ _____

I would like my gift to benefit: (Please check one option)

- Rutland Regional Medical Center
- Rutland Area Visiting Nurse Association & Hospice Dorset Nursing Assoc. Kids on the Move
- Rutland Health Foundation

- Please use my gift in the area of greatest need in the above checked organization.
- I'd like my gift to benefit the following program or fund: _____

Personal Information

Title: (Please check one option) Mr. and Mrs. Ms. Mr. Mrs. Dr.

First name _____ Last name: _____

Street or PO Box: _____

City: _____ State and Zip: _____

Phone: _____ Email: _____

Payment Information

Select credit card type: (Please check one option) American Express. MasterCard. Visa.

Name as it appears on your credit card: _____

Credit card number _____

Expiration Month _____ Year: _____

Your signature: _____

Enclosed is my check. (Checks made payable to the Rutland Health Foundation)

Gift Information

- This gift is not an honor or memory gift.
- I/We make this gift in memory of _____
- I/We make this gift in honor of _____

Please notify the following that we have made this gift:

Title: (Please check one option) Mr. and Mrs. Ms. Mr. Mrs. Dr.

First name _____ Last name: _____

Street or PO Box: _____

City: _____ State and Zip: _____

Phone: _____ Email: _____

May we contact you?

- Yes, please add me to your mailing list to receive publications, appeals for support and event invitations
- No, thank you. I'd rather not receive mailings from the Rutland Health Foundation or its' member organizations at this time.

If you have any questions regarding making a donation to the Rutland Health Foundation, please call 802.747.3634.