St. Charles Hospital
FOUNDATION
YOUR HEALTH, OUR MISSION

DONATION FORM

Name: _____ **Today's Date** _____

Company/Organization: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____ **Email:** _____

Information taken by: _____

Amount: $_____

Purpose of donation: _____

Donation to benefit: _____

Acknowledgement to be mailed to: **(☐ Check here if same as address above)**

Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Monetary Donation

☐ **Cash** ☐ **Check (made payable to St. Charles Hospital Foundation)**

☐ **Charge (fill information below:)** ☐ MasterCard ☐ VISA ☐ AMEX * NO DISCOVER

Card #: _____

3 Digit # (from back of card): _____

Exp. Date: _____ **Amount: $**_____

Cardholder: _____

Signature: _____

Mail this completed form to the St. Charles Hospital Foundation
200 Belle Terre Road, Port Jefferson, NY 11777