DONATION FORM

Thank you for considering a gift in support of Mountains Community Hospital.
Please complete the following information and mail it with your gift to:

Mountains Community Hospital
PO Box 70
Lake Arrowhead, CA. 92352

Name:____

Company Name: (if applicable)________________________________

Address:____

City:________________________ State:________ Zip Code:______

Day Telephone #____________________ FAX # __________________

Email address:____________________________

Gift Amount: $______________

( ) Check #:__________________ is enclosed, made payable to MCH Foundation.

( ) Credit Card Payment-Please charge my credit card as provided below:

Type of Credit Card: ( ) Visa ( ) Master Card ( ) American Express

Credit Card #:_______________________________

Expiration: ______/______ 3-Digit Verification Code: _______

Name as it appears on card _______________________________
Print

Signature:__________________________ Date: ______________

I would like to donate to:

- Palliative Care
- Long Term Care
- Lifeline
- Surgical Equipment
- Where Most Needed

If you have any questions or require additional information,
please contact the Foundation at 909/436-3263

Thank you for your support!