Financial Contribution

Vernon Memorial Healthcare Foundation

about you

first name ______ middle name ______ last name ______

address ______ city ______ state ______ zip ______

email address ______ phone ______ fax ______

about your gift

my gift is in ☐ memory of *or* ☐ honor of ______

value of tax-deductible contribution

$ ______

please use my gift for...

☐ the area of greatest need
☐ hospice care ☐ the Bland Bekkedal Center
☐ the transplant support group ☐ cardiac rehabilitation
☐ scholarships ☐ the Center for Special Children
☐ medical equipment purchases
☐ community health education programs

☐ other ______

☐ I would like my gift to remain anonymous
☐ please send an acknowledgment of my gift to...

name ______ relationship ______

address ______

city ______ state ______ zip ______

payment

☐ mastercard ☐ discover ☐ visa

☐ cash

☐ check # ______

Please make checks payable to
Vernon Memorial Healthcare Foundation

name as printed on card ______ credit card number ______

credit card billing address ______ city ______ state ______ zip ______

expires ______ CVC (3-digit # on back) ______ signature ______ date ______

Thank you for partnering with us to meet the health care needs of our community.

Please return your completed form to:
Vernon Memorial Healthcare Foundation
507 S. Main Street, Viroqua, WI 54665
(608) 637-4374 foundation@vmh.org www.vmh.org

for office use

deposited ______

acknowledged ______