



Donation Form

Please print clearly

Title: _____ First Name: _____ Last Name: _____
(Mr., Mrs., Ms.)

Street Address: _____

City: _____ State: _____ Zip: _____

Telephone No.: _____ E-mail: _____

Donation Amount: \$ _____ Donation Method: Check No.: _____

Type of Credit Card: American Express MasterCard Visa Discover

Credit Card No.: _____ - _____ - _____ - _____ Exp. Date: _____ CVV Code: _____

Name on Credit Card: _____

This donation is in **memory** / **honor** (circle one) of: _____

Would you like us to inform someone of this donation?

Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Please indicate how you would like your name to appear in Blythedale publications (if applicable):

_____ Anonymous

This gift is potentially matchable by my employer

**Many companies participate in Matching Gift Programs that will enable you to increase the impact of your gift to Blythedale. If your company has a Matching Gift Program, please follow their guidelines in order to submit your gift for a company match.*

Please send your completed donation form to:

Blythedale Children's Hospital
Development Department
95 Bradhurst Avenue
Valhalla, NY 10595-1697

*Blythedale Children's Hospital is a tax-exempt organization described in Section 501(c)(3) of the IRS code.
Your contribution is tax-deductible to the extent allowed by law.*