DONOR COMMITMENT FORM

Donor Name/Business (for recognition) _____

Contact Name (please print) _____

Address _____

City _____ State _____ ZIP _____

Home Phone _____ Business Phone _____

Cell Phone _____ E-mail _____

☐ I/We pledge the total of $_____, payable over _____ years to Susquehanna Health Foundation starting (month/year) _____.

☐ Please invoice me: ☐ Quarterly ☐ Semi-Annually ☐ Annually

☐ Please charge my contribution to a credit card:

Card Number _____ Expiration Date (mm/yy) _____

Name on Card _____

☐ Please accept the enclosed check in the amount of $ _____
(payable to Susquehanna Health Foundation)

☐ Please contact me about a gift of negotiable securities.

☐ Please contact me to discuss the Legacy Society and/or other planned gifts.

☐ Please contact me to discuss my employer's matching contribution.

☐ Please make my gift

☐ In Honor of ☐ In Memory of _____

Signature(s) _____ Date _____

Naming opportunities begin at $50,000 and recognition remains for a minimum of 20 years.

Comments:

Susquehanna Health Foundation
1001 Grampian Boulevard
Williamsport, PA 17701
570-320-7460
Fax: 570-320-7467
UPMCSusquehanna.org/Donate

SUSQUEHANNA
HEALTH FOUNDATION