



DONOR INFORMATION

Date _____

Name(s) _____

Address _____

City/St/Zip _____

Phone _____

E-mail _____

PLEDGE

- I/we are committing to a one-time gift of \$ _____ is enclosed.
- I/we pledge a total of \$ _____ to be paid over _____ years (up to 3 years) with _____ installments of \$ _____ made: Annually Semiannually Quarterly
- The first payment to begin on (date) _____ .
- I/we would like to be contacted about including Regional Medical Center in my will.
- I/we would like to be contacted about ways to donate stock, grain, or other commodities.

THIS GIFT IS MADE (CHECK ALL THAT APPLY)

- in our name (as noted above) anonymously
- in memory of OR in honor of _____
- to be used as RMC deems appropriate
- to RMC's endowment through the Community Foundation of Greater Dubuque
- to a specific department _____

TO PAY BY CHECK

Please make checks payable to Regional Medical Center. Send this completed form with payment to Regional Medical Center, ATTN Donations, PO Box 359, Manchester, IA 52057.

Donor Signature

Date

Donor Signature (optional)

Date

WHO IS ON THE WALL

The Giving Wall recognizes those who have contributed cumulative gifts of \$1000+.

NAMING OPPORTUNITIES

- Specialty Clinic Exam Rooms: \$15,000
- Inpatient Rooms: \$25,000
- Radiology Waiting Room: \$50,000

QUESTIONS?

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