St. Rose Dominican Health Foundation
A member of CHW

Donation Form

Name_____
Address_____
City_____ State_____ZIP _____
Phone (H)_____ Phone (C) _____
E-mail _____

Circle One: Cash Check Credit

Please make your check payable to St. Rose Dominican Health Foundation

For a credit card gift, please complete the information below:

I authorize the St. Rose Dominican Health Foundation to charge $_____ using the following credit card:

Master Card ____ Visa ____ AmEx ____ Discover____
Name as it appears on card_____
Credit Card Number_____
Expiration Date_____
Signature_____

My gift is in honor/memory of:_____
Please notify:_____
Name Address City State ZIP

I would like designate my gift for the following area at St. Rose Dominican Hospitals:

_____ Area of Greatest Need
_____ Children's Miracle Network
_____ Siena Campus
_____ Community Outreach Programs
_____ Volunteer Department
_____ Rose de Lima Campus
_____ San Martín Campus
_____ Mission Services
_____ WomensCare Center
_____ Hospice
_____ Other (please list) _____

Please return this form to the following address:

St. Rose Dominican Health Foundation
3001 St. Rose Parkway
Henderson, NV 89052

If you have any questions, please contact us at (702) 616-5750
Thank you for your support.
Tax ID# 88-0349432