



# Thank you for helping dreams come true at Shriners Hospitals for Children



Your tax-deductible gift to Shriners Hospitals will help an orthopedically impaired or burned child and serve to commemorate a loved one, a friend, or an event. Each gift is acknowledged to the donor. A card announcing the gift is sent to the person being remembered or to the family who has lost a loved one. The amount of the gift is not mentioned.

Please mail to: Shriners Hospitals for Children, Office of Development  
2900 Rocky Point Drive, Tampa, FL 33607-1460 (Credit card gifts can be faxed to (813) 281-7156)

## DONOR INFORMATION: (Please Print)

Mr.    Mrs.    Mr. & Mrs.    Other: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
Donor's Name: \_\_\_\_\_ Email: \_\_\_\_\_  
Donor's Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

## CONTRIBUTION METHOD:

Check Enclosed       Please Charge my Credit Card:    MasterCard    Visa  
 This is a one-time gift.

Please charge this amount each **month** until \_\_\_\_\_ (date).  
 Please charge this amount each **quarter** until \_\_\_\_\_ (date).  
Signature to authorize recurring gift: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Name as it appears on Credit Card: \_\_\_\_\_  
Credit Card Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_  
Authorization Signature: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
Enclosed is a contribution of \$ \_\_\_\_\_ (US), payable to Shriners Hospitals for Children

## CREDIT TO:

Hospital: \_\_\_\_\_ Temple: \_\_\_\_\_  
Club/Unit: \_\_\_\_\_ Other: \_\_\_\_\_

## GIFT INFORMATION:

In Memory of: \_\_\_\_\_  
Relation to the Deceased: \_\_\_\_\_  
 In Honor of: \_\_\_\_\_  
 On the Occasion of: \_\_\_\_\_  
Send gift announcement to:  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Please send me information about Shriners Hospitals' planned giving opportunities.