



Powell Medical Foundation

DONATION FORM

Please print off this form and mail to Powell Medical Foundation at the address below.

Gift Information

Gift Amount \$ _____ . ____

Please designate my gift as:

- Undesignated - Foundation Board will determine greatest area of need
- Endowment The Heartland
- Powell Valley Hospital Scholarship Fund
- Powell Valley Care Center Powell Valley Hospice
- Other (please specify) _____

In memory of _____

In honor of _____

Without mentioning the amount, please send acknowledgement of my gift to:

Name _____
Address _____
City _____
State/ZIP _____

Your Information

Donor Name: _____

Address: _____

City: _____ State _____ ZIP _____

Phone: _____ E-mail Address: _____

Payment Information

- My check is enclosed
- Please charge my VISA Mastercard Discover

Account Number: _____ Exp Date _____

Name as it appears on Card: _____

Signature _____

Please return this form with your payment to the address below:

Powell Medical Foundation, 777 Avenue H, Powell, WY 82435, 307-754-7746, FAX 307-754-7747