DONATION FORM

DONOR (Please print or type. One donor name per form, please.)

(Name as it should appear in recognition materials including blank boxes between words, etc. 35 total characters/boxes maximum)

DONOR CONTACT INFORMATION

Last Name	First Name	Middle Initial	Title (Mr., Ms., Mrs., etc)
Mailing Address			
City		State	Zip

Home/Work	Cell	Fax	Email

(We will contact you if clarity is needed on donor listing, item, restrictions, etc.)

ITEM INFORMATION

Item name & Description ☐ Check if restrictions apply (and list below or continue on back)	Value: $ _____. ____
Is there more than one donor for this item? ☐ No ☐ Yes (if so, please fill out one form per donor and ensure item name is identical.)	
Item is (please check one): ☐ Was delivered to: ☐ To be picked up ☐ Included with form	

FINANCIAL CONTRIBUTION

If making a financial contribution, please enclose a check or complete the credit card information below:

Amount: $ _____.____	
☐ VISA ☐ MASTERCARD ☐ DISCOVER ☐ AMEX Card No.:	Exp: ____/20____ CVV: _____
Name on Card:	Signature:

SIGNATURE

I agree to donate the above listed item(s) to Harrison Medical Center. Your donation is tax deductible under Harrison Medical Center Foundation Tax ID No. 91-1197626. Please consult with your financial advisor as to the tax deductible benefits of your donation.

Signature	Date

FOR PROCUREMENT/OFFICE USE ONLY

Procured by	Date Received
	Rcvd: _____ Item Number: _____

Return Form To:

Harrison Medical Center Foundation

2520 Cherry Avenue ▪ Bremerton, WA 98310 ▪ Ph: (360) 337-8110 ▪ Fax: (360) 337-8114