



# GIVING FORM

Ms.  Mrs.  Mr.  Mr. and Mrs.  Dr.

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone Day: \_\_\_\_\_ Business: \_\_\_\_\_

E-mail: \_\_\_\_\_

***I would like to make a gift of:***

\$1,000  \$500  \$250  \$100  Other \_\_\_\_\_

Please charge my:  MasterCard  Visa  Discover  American Express

Card Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

***My Gift is for:***  The Women & Children's Hospital of Buffalo Foundation

I would like my gift restricted to the following area at Women & Children's Hospital:

\_\_\_\_\_

***Please list this gift from:*** \_\_\_\_\_  This gift is anonymous. Please do not list my name in publications.

This gift is  in memory of:  in honor of:

Name \_\_\_\_\_ Please Notify \_\_\_\_\_

Occasion \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone \_\_\_\_\_

I have remembered Women & Children's Hospital or program in my will or estate.

I would like to know how to remember Women & Children's Hospital or program in my will or estate plans.

I would like to learn about a gift that pays income to me.

***Make checks payable to the  
WCHOB Foundation  
and mail to:***

Women & Children's Hospital of Buffalo Foundation  
1260 Delaware Avenue  
Buffalo, NY 14209

***Thank you for your gift!***

**Questions?** Please call the Foundation office at (716) 881-8230.  
fax: 716-882-4054

