



## GIVING FORM

Name \_\_\_\_\_

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

Telephone Day \_\_\_\_\_ Business \_\_\_\_\_ Email \_\_\_\_\_

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### 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:

- Where need is greatest
- Buffalo General Hospital
- DeGraff Memorial Hospital
- Millard Fillmore Gates Hospital
- Millard Fillmore Suburban Hospital
- Visiting Nursing Association of WNY
- Women & Children's Hospital of Buffalo

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

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**This gift is**  in memory of:    in honor of:

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

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

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

- I have remembered my favorite Kaleida Health hospital or program in my will or estate.
- I would like to know how to remember my favorite Kaleida Health hospital or program in my will or estate plans.
- I would like to learn about a gift that pays income to me.

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### Make checks payable to *The Women & Children's Hospital of Buffalo Foundation* and mail to:

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

