

170 William Street New York, NY 10038 (212) 312-5000

DEVELOPMENT OFFICE (212) 801-1700

Today's Date:

DONATION FORM

Yes! I wish to make a 100% tax-deductible donation in the amount of: \$75	Your 100% tax-dedu work as the only ho		ation to New York Dow ower Manhattan.	ntown Hospital	will support its life-s	aving
State: Zip: Daytime Telephone: Email: Discrete Reck where appropriate: Enclosed please find my check made out to NEW YORK DOWNTOWN HOSPITAL Mail to: Development Office New York, NY 10038 Charge my credit card. American Express MasterCard VISA Credit Card #: Expiration Date:/ Please specify amount to be charged \$ Card Holder Name:/ Card Holder Name:/ City in with to make this gift anonymously. In Memory of	Yes! I wish to make	e a 100% ta	x-deductible donation	in the amount o	f:	
□ This gift can be matched by my employer. The completed form is enclosed. □ I wish to make this gift anonymously. □ I wish to make this gift: In Honor of	\$75	□ \$100	\$250	□ \$500	□ \$1,000	
□ I wish to make this gift anonymously. □ I wish to make this gift: In Honor of	\$1,500	\$2,500	□ \$5,000	□ \$10,00	00	S
Donor Name: (Dr. / Mr. / Mrs. / Ms.) Individual Company Foundation Organization	☐ This gift can be mat	ched by my e	mployer. The completed for	m is enclosed.		
Donor Name: (Dr. / Mr. / Mrs. / Ms.) Individual Company Foundation Organization Preferred address: Home Business Company:	☐ I wish to make this g	gift anonymou	usly.			
Preferred address:	☐ I wish to make this g	gift: In Honor	of	In Men	nory of	
Preferred address:	Donor Name: (Dr. / I	Mr /Mre /M	Me)			
Company:	·		•			
Company:	Preferred address: □	Home □ E	Business			
Address:				Title/Dept:		
City: State: Zip: Daytime Telephone: Email: Your information will not be sold or exchanged. Please check where appropriate: Enclosed please find my check made out to NEW YORK DOWNTOWN HOSPITAL Mail to: Development Office						
Please check where appropriate: Enclosed please find my check made out to NEW YORK DOWNTOWN HOSPITAL Mail to: Development Office New York Downtown Hospital 170 William Street, New York, NY 10038 Charge my credit card. American Express MasterCard Expiration Date: Please specify amount to be charged \$						
Please check where appropriate: Enclosed please find my check made out to NEW YORK DOWNTOWN HOSPITAL Mail to: Development Office New York Downtown Hospital 170 William Street, New York, NY 10038 Charge my credit card. American Express MasterCard Expiration Date: Please specify amount to be charged \$ Card Holder Name: Signature:						
Please check where appropriate: Enclosed please find my check made out to NEW YORK DOWNTOWN HOSPITAL Mail to: Development Office New York Downtown Hospital 170 William Street, New York, NY 10038 Charge my credit card. Credit Card #: Please specify amount to be charged \$ Card Holder Name: Signature:	•					
Mail to: Development Office New York Downtown Hospital 170 William Street, New York, NY 10038 Charge my credit card. American Express MasterCard VISA Credit Card #: Expiration Date:/ Please specify amount to be charged \$ Card Holder Name: Signature:						
Credit Card #: Expiration Date:/ Please specify amount to be charged \$ Card Holder Name: Signature:	Mail to: Deve New	elopment Of York Down	ffice town Hospital		N HOSPITAL	
Please specify amount to be charged \$ Card Holder Name: Signature:	☐ Charge my credit	card.	☐ American Express	■ MasterCard	□ VISA	
Card Holder Name: Signature:	Credit Card #	# :			Expiration Date:	
	Please speci	fy amount to	o be charged \$			
	Card Holder	Name:		Signatu	re:	

Thank you for supporting Lower Manhattan's only hospital!
For more information about Downtown Hospital. please visit our website at

Please contact Development Office at (212) 801-1700 for any inquiries regarding this donation.

FAX THIS FORM TO: (212) 801-1711

For more information about Downtown Hospital, please visit our website at www.downtownhospital.org or call us at (212) 312-5000