



**Sutter Medical Center
of Santa Rosa**

Donation Form

Fund Development Office

3325 Chanate Road
Santa Rosa, CA 95404
(707) 576-4009
(707) 576-4054 Fax
www.suttersantarosa.org

Please complete and return this donation form to the Fund Development Office (via mail or fax)

- Enclosed is my gift of \$ _____
 - My check is enclosed (*payable to Sutter Medical Center of Santa Rosa*)
 - Please charge my MasterCard, Visa, or American Express (*circle card*)
 - Card # _____ Exp. Date _____
 - Signature _____

- I would like to donate stocks or real estate, please contact me.
- Tell me how to include SMCSR in my will and/or trust.

I would like my gift to support:

- Women’s Health Services
- Heart & Vascular Services
- Children’s Services
- Residency Program
- Area of greatest need

The Gift is Given: (Optional)

- In Memory of _____
- In Honor of _____
- Please thank a specific hospital unit or individual

Donor Information: (Please Print)

Name I would prefer to remain anonymous

Address

City State Zip

Phone Number Additional Contact Number E-mail address

If gift is “in honor” of or “on behalf” of, send additional acknowledgement to: (optional)

Name of person I wish to inform

Address

City State Zip

*Thank you for your tax-deductible contribution to support Sutter Medical Center of Santa Rosa.
The amount of your gift is confidential. Federal Tax ID #68-0374805*