TRINITY HEALTH SYSTEM FOUNDATION

# Capital Campaign Contribution

**Donor Information (please print or type)**

| | |
|---|---|
| Name | |
| Home address | |
| City | |
| State | |
| ZIP Code | |
| Telephone | |

**Pledge Information**

**I pledge a *total* of $_____ to be paid:**

☐ now ☐ $_____/month ☐ $_____/quarter ☐ $_____/Annually

**Reoccurring invoice to be sent/start:_____(Month & date)**

**I plan to make this contribution in the form of:**

☐ cash ☐ check ☐ credit card ☐ payroll deduction

**All credit card donations please call the Marketing and Development office at 740-283-7241**

**I wish to restrict my contribution to:**

☐ Behavioral Health ☐ Birth Center ☐ Cardiac Services

☐ Emergency Services ☐ Mammography Center ☐ Medical Equipment

☐ Oncology Equipment ☐ Orthopedics & Sports Medicine ☐ Future Building Expansion

**Acknowledgement Information**

Please use the following name(s) in all acknowledgements:

| |
|---|
| |

☐ I (we) wish to have our gift remain anonymous.

| | |
|---|---|
| Signature(s) | Date: |

**Please Return to:**

**TRINITY HEALTH SYSTEM FOUNDATION OFFICE**
**380 SUMMIT AVE**
**STEUBENVILLE, OH 43952**