



**Please send or fax completed form to:**  
 Miami Children's Hospital Foundation  
 3000 SW 62<sup>nd</sup> Avenue  
 Miami, FL 33155  
**Phone:** 305-666-2889 **Fax:** 305-666-3078

# Donation Form MCHFONL

## Donation Information

Amount \$ \_\_\_\_\_

Please use my donation  where it is needed most  
 to support a specific area in the hospital. (Please specify) \_\_\_\_\_  
 to support an endowment or chair. (Please specify) \_\_\_\_\_

## Personal Information

Title (Please select one)  Mr. & Mrs.  Miss  Mr.  Mrs.  Ms.  Dr.

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_

Home Address  Business Address -- Company Name \_\_\_\_\_

Street \_\_\_\_\_ Apartment or Suite Number \_\_\_\_\_

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

Phone: Home ( ) \_\_\_\_\_ Business ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_

Email address: \_\_\_\_\_  Yes  No I would like to receive email updates

## Donation Method

Credit Card  Check (Please make checks payable to **MCH Foundation**)

## Credit Card Information

Select card type (Please select one)  American Express  Visa  MasterCard  Discover

Name as it appears on your credit card \_\_\_\_\_

Credit Card Number \_\_\_\_\_ Expiration Date (month/year) \_\_\_\_/\_\_\_\_

Signature \_\_\_\_\_

## Employer Matching (optional)

Yes, my employer will match my donation.

## Company Information

Company Name \_\_\_\_\_

Street \_\_\_\_\_ Suite Number \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone ( ) \_\_\_\_\_

## Tribute Gift Information (optional)

I'd like to make this gift in memory of \_\_\_\_\_  
 I'd like to make this gift in honor of \_\_\_\_\_

**Notification that a tribute donation has been made will be sent to the person you indicate below:**

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Street \_\_\_\_\_ Apartment or Suite Number \_\_\_\_\_

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