SSM Health Cardinal Glennon Children's Foundation

MONETARY DONATION FORM

Donor Information

Donation is from an individual: ☐ *(proceed tosection A)* **Donation is from an organization:** ☐ *(proceed to section B)*

Section A: Individual Information:

Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss. ☐ Dr. ☐ Other:_____ **Marital Status:** ☐ Single ☐ Married ☐ Widowed

First Name:_____ **M.I.**_____ **Last Name:**_____ **Suffix:**_____

Address:_____ **City, State, Zip:** _____

Preferred Phone:_____ **Preferred Email:** _____

Birthdate:_____ **Spouse Name:** *(if applicable)* **Spouse Birthdate:** *(if applicable)* _____

Section B: Organization Information:

Organization Name:_____ **Contact Name:** _____

Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss. ☐ Dr. ☐ Other:_____ **Position:**_____

Address:_____ **City, State, Zip:** _____

Preferred Phone:_____ **Preferred Email:** _____

Section C: Exceptional Care Section:

☐ **I have personally experienced the exceptional care provided by SSM Health Cardinal Glennon Children's Hospital**

☐ **A member of my family has experienced the exceptional care provided by SSM Health Cardinal Glennon Children's Hospital.**

Donation Information

Donation Amount:_____ **Donation Date:** _____ **Gift is Anonymous:** ☐

Designation/Restriction:_____

What prompted donation (Appeal): _____

Form of Payment: *(circle one)* **Cash** **Check** **Cash & Check** **Credit Card**

Credit Card Information *(complete if form of payments selected above is credit card)*

Card Type: *(circle one)* **VISA** **MasterCard** **Discover** **AMEX**

Name on Card: _____

Account #: _____ **Expiration Date:**_____

Personal card: ☐ ***Business Card:*** ☐

One-Time: ☐ **Monthly:** ☐ Begin on:_____ End on: _____

Honor/Memorial Information

Complete this section if donation is being made in Honor or Memory of someone

Name: _____

☐ **In Honor**
☐ **In Memory**

Notification to be sent to:

Name: _____
Address: _____
City, State & ZIP: _____

Internal Office Use Only

Completed by: _____ **Submit Date:** _____