

Children's Healthcare of Atlanta Foundation Donation Form
Please print and complete this form to make a gift to Children's Healthcare of Atlanta

Your name as you wish it to appear in printed material _____

Company (if corporate gift) _____

Address _____

City _____ State _____ Zip _____

Daytime Phone _____ Email _____

I would like to support Children's Healthcare of Atlanta with a gift of: \$ _____

_____ Check Enclosed _____ AMEX _____ MasterCard _____ Visa _____ Discover

Card Number _____ Exp. _____ / _____

Signature _____
(required for all credit card charges)

I would like my gift to support: _____

**** *If your employer will match your gift, please enclose completed form.* ****

Tribute – I would like my gift to be in honor or in memory of a special person:

My gift is: _____ in honor of _____ in memory of _____
(please print tribute name)

Please Notify:

Name _____

Address _____

City _____ State _____ Zip _____

Thank you for supporting Children's Healthcare of Atlanta!

_____ I would like to receive a gift envelope to help make future gifts.

_____ I would like to receive information on volunteering in the hospital.

_____ I would like to receive information about including Children's Healthcare of Atlanta in my will or estate plan.

Please mail this form along with your donation to:

Children's Healthcare of Atlanta
ATTN: Gift Processing Area
1687 Tullie Circle
Atlanta, GA 30329
For questions, call 404-785-7310