

Donor Information

Mr.  Mrs.  Ms.  Dr.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Work Telephone: \_\_\_\_\_

Preferred Email: \_\_\_\_\_

1. Select a Donation Option

My gift is enclosed in the amount of \$\_\_\_\_\_

Check enclosed made payable to the **Winona Health Foundation**

Cash

**Please charge my:**  VISA  MasterCard  Discover  American Express

Card #: \_\_\_\_\_

Security Code: \_\_\_\_\_ Exp. Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name as it appears on card: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

2. Designate Your Gift

**Please direct my gift to:**

Ben & Adith Miller Patient Care Fund

Area of Greatest Need

Lake Winona Manor

Other: \_\_\_\_\_

Hospice

3. In Honor/In Memory of (optional)

**Please accept this gift:**

In honor of  In memory of

Name: \_\_\_\_\_

**Please send notification of this gift to:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship to Tributee: \_\_\_\_\_