



Please send or fax completed form to:
Miami Children's Hospital Foundation
3100 SW 62nd 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 _____