Gift Designation Form

Name: __________________________________________ Address Information

Email: __________________________________________ Address Line: ______________________________________

Phone: ________________________________________ City, St Zip: ______________________________________

Signature: ______________________________________ Date: __________________________________________

Designation:

I would like my donation to support: ______________________________________________________________

Please indicate how you would like your donation to be used if you wish to support a specific department, program, capital project, etc.

One Time Donation

☐ Enclosed is my check for the amount of $__________ made payable to MarinHealth Foundation.

☐ I would like to make a onetime gift for the amount of $__________ with the following credit card:

☐ MasterCard ☐ Visa ☐ Discover ☐ American Express

Credit Card Number: _____________________________ Expiration Date: __________

Recurring Credit Card Donation

☐ I would like to make a recurring gift for the amount of $__________ (please enter the amount you would like to donate each time your card is processed) beginning __________ (please enter the date you would like your recurring gift to begin).

Payments will be made: ☐ Annually ☐ Semi-annually ☐ Quarterly ☐ Monthly

I would like to make my gifts with the following credit card:

☐ MasterCard ☐ Visa ☐ Discover ☐ American Express

Credit Card Number: _____________________________ Expiration Date: __________

Pledge Commitment

☐ I would like to make a pledge for the amount of $__________ that will be paid over _______ years. The first payment will be made ______/_____/ (Month/Year).

Payments will be made: ☐ Annually ☐ Semi-annually ☐ Quarterly ☐ Monthly ☐ One-time

I plan to pay this pledge by:

☐ Check made payable to MarinHealth Foundation.

☐ I would like to make a payment with the following credit card:

☐ MasterCard ☐ Visa ☐ Discover ☐ American Express

Credit Card Number: _____________________________ Expiration Date: __________

For recognition purposes:

☐ I would like to be recognized as: _________________________________________________________________

☐ I prefer to remain Anonymous

If you have any questions or if you need stock or wire transfer instructions, please contact Jason Krasko at:

Phone: 415-925-7425
E-Mail: kraskoj@mymarinhealth.org

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Foundation