



KALEIDA HEALTH FOUNDATION

GIVING FORM

Name _____

Address _____ City _____ State _____ Zip Code _____

Telephone Day _____ Business _____ Email _____

.....
I would like to make a gift of:

\$1,000 \$500 \$250 \$100 Other _____

Please charge my: MasterCard Visa Discover American Express

Card Number: _____ Expiration Date: _____

My Gift is for:

- Where need is greatest
- Buffalo General Hospital
- DeGraff Memorial Hospital
- Millard Fillmore Gates Hospital
- Millard Fillmore Suburban Hospital
- Visiting Nursing Association of WNY
- The Women & Children's Hospital of Buffalo Foundation

Please list this gift from: _____ This gift is anonymous. Please do not list my name in publications.

.....
This gift is in memory of: in honor of:

Name _____ Please Notify _____

Occasion _____ Address _____

City _____ State _____ Zip Code _____

- I have remembered my favorite Kaleida Health hospital or program in my will or estate.
 - I would like to know how to remember my favorite Kaleida Health hospital or program in my will or estate plans.
 - I would like to learn about a gift that pays income to me.
-

Make checks payable to the Kaleida Health Foundations and mail to:

Kaleida Health Foundations
1260 Delaware Avenue
Buffalo, NY 14209

