



Ms. Mrs. Mr. Mr. and Mrs. Dr.

Name: _____

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Telephone Day: _____ Business: _____

E-mail: _____

I would like to make a gift of:

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

Please charge my: MasterCard Visa Discover American Express

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My Gift is for:

- Adult Day Care Centers (Amherst • Tonawanda)
- Buffalo General Medical Center
- DeGraff Memorial Hospital
- Gates Vascular Institute
- HighPointe on Michigan
- Millard Fillmore Suburban Hospital
- The Women & Children's Hospital of Buffalo Foundation
- Visiting Nursing Association of WNY
- Where need is greatest

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.

Thank you for your gift!

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

Kaleida Health Foundations
1260 Delaware Avenue
Buffalo, NY 14209

Questions? Please call the Foundation office at (716) 881-8260.

