The Foundation
Sheridan Memorial Hospital

Transforming Transitional Care

Pledging to ensure Medical Excellence - Right Here at Home

Name(s):_____

Print your family or corporate name as you would like it to appear in Foundation publications.

☐ **Please check here if you wish to remain anonymous.**

Mailing Address: _____

E-Mail Address: _____ **Phone:** _____

Cash Payment Options:

One time cash/check/charge gift of: $_____ to be paid on date: _____ _____

My check in the amount of $_____ is enclosed *(Make checks payable to SMH Foundation)*

☐ Charge to my Visa/Mastercard (circle one) ☐ ACH (Contact The Foundation)

Account #: _____ Exp.Date: _____ Auth Code: _____

5 Year Pledge Options	
$250	$50/yr
$500	$100/yr
$1,000	$200/yr
$2,500	$500/yr
$5,000	$1,000/yr
$10,000	$2,000/yr

Pledge Payment Options: My pledge is: $_____ Payable over ___ years

Annually, Quarterly, Monthly, or as requested. (circle one)

Beginning in _____ 20____
Month Year

Enclosed: $_____ Balance: $_____ *Pledge reminders will be sent as requested above.*

☐ This gift is in **Honor** or **Memory of** _____
(circle one) *(Name)*

Signature _____ Date _____

Print Name(s): _____

Sheridan Memorial Hospital Foundation has a gift acceptance policy in place, and available for review upon request. Contact the office at (307)673-2418. All contributions are tax-deductible under section 501(c)(3) of the Internal Revenue Service Code.

PO Box 391 | Sheridan, WY 82801 | 307-673-2418
foundation@sheridanhospital.org