



CAMPAIGN CONTRIBUTION FORM

NAME(S): _____

(Please write your name as you wish to be recognized)

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

EMAIL: _____

PHONE: _____

My total pledge/gift amount is \$ _____

Please choose one:

Contribution is a pledge. My/Our intended payment schedule is:

Contribution is enclosed

Please charge my Credit Card:

CHECK VISA MC AMEX DISCOVER

CREDIT CARD NUMBER: _____

EXP. DATE: _____ SECURITY CODE (CSC): _____

NAME ON CARD: _____

SIGNATURE: _____

SIGNATURE: _____ **DATE:** _____

Please make checks payable to:
Hudson Headwaters Health Network
Federal Tax ID: 14-1628237

For questions, please contact:
development@hhhn.org

HHHN.org