

I (we) support West Shore Medical Center's expansion for the future through the enclosed gift of:

- \$1,000 \$250 \$50
 \$500 \$100 \$25
 Other _____

This gift is given by:

Name _____
(Please print your name as you would like it to appear for recognition purposes.)

Address _____

City _____ State _____ Zip _____

Phone number _____

I prefer that this gift remain anonymous.

*Your gift is tax deductible to the full extent of the law. Please make checks payable to
West Shore Healthcare Foundation and mail to:
P.O. Box 541
Manistee, MI 49660*

This gift is given in memory/honor (circle one) of:

Please send acknowledgement to:

Name _____

Address _____

City _____ State _____ Zip _____

Please charge my: Visa MasterCard

Account number _____ Exp. Date _____

Signature _____

I would like information about making a bequest to West Shore Medical Center.

My employer will match this gift. (Please enclose matching gift form.)

Employer _____