IVCHF

Grateful Patient PROGRAM

Say thank you in a meaningful way

DONOR INFORMATION

Name: _____

Billing Address: _____

Email: _____ Phone: _____

PAYMENT INFORMATION

I am pleased to support the Incline Village Community Hospital Foundation in the amount of:

$ _____ In Honor of: _____

_____

❍ Enclosed is my check made payable to IVCHF ***(880 Alder Ave, Incline Village, NV 89451)***

❍ Please charge my MasterCard/Visa/Amex

Account #: _____ Expiration Date: _____ CVV#: _____

Signature: _____

GIFT DESIGNATION

❍ Area of Greatest Need

❍ Emergency Services

❍ Other: _____

Incline Village Community Hospital Foundation is a non-profit 501 (c) (3), tax ID #20-0752156. Donations are tax deductible to the full extent of the law.