HEALTHCARE REINVENTED
THE CAMPAIGN FOR TRINITY HEALTH SYSTEM

CAPITAL CAMPAIGN CONTRIBUTION

DONOR INFORMATION

Name	
Home Address	
City	
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Zip Code	
Phone Number	
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PLEDGE INFORMATION

I pledge a total of $_____ to be paid:

☐ Now ☐ $_____/month ☐ $_____/quarter ☐ $_____/annually

Recurring invoice to be sent/start: _____ (month & date)

I plan to make this contribution in the form of:

☐ Cash ☐ Check ☐ Credit Card ☐ Payroll Deduction

Please call the Marketing and Development office at 740.283.7241 for all credit card donations.

CAPITAL CAMPAIGN FUNDS

Please restrict my gift in the following capital campaign fund: (Please choose ***ONLY ONE.***)

☐ Behavioral Health ☐ Emergency Services ☐ Oncology

☐ Birth Center ☐ Future Building Expansion ☐ Orthopedics/Sports Medicine

☐ Cardiac Services ☐ Medical Equipment ☐ Women's Imaging

ACKNOWLEDGEMENT INFORMATION

Please use the following names in all acknowledgements:

_____

☐ I (we) wish to have our gift remain anonymous.

Signature(s): _____ Date: _____

THANK YOU FOR YOUR DONATION!

Please return to: Trinity Health System Foundation Office | 380 Summit Ave. | Steubenville, OH 43952
foundation@trinityhealth.com | Fax: 740.283.7538