Goshen Health
FOUNDATION

Grateful Patient Program

I would like to honor:

_____
(Name of physician, nurse, support staff, volunteer or other caregiver)

Hospital Floor or Department: _____

_____

Comments about your honoree: _____

_____

_____

_____

_____

❑ $1,000 ❑ $500 ❑ $250 ❑ $100
❑ $50 ❑ $25 ❑ Other $ _____

With a one-time contribution of:

❑ Check enclosed (Payable to Goshen Health Foundation)
❑ Charge to my credit card: (Please circle card type)
Mastercard Visa Discover

Name on Card: _____

Card#: _____ Exp: _____

Signature: _____

Date: _____

With monthly giving:

I want to provide a gift of $ _____
each month for ❑ 12 months ❑ 24 months

Enter credit card information above, or you may send a monthly check.

To benefit the following fund:

❑ Cancer Research
❑ Goshen Cancer Survivor Network
❑ Goshen Center for Cancer Care
❑ Heart & Vascular Center
❑ HeartStrings Sisters
❑ Hospice
❑ NeuroCare Center
❑ Patient Assistance at Goshen Center for Cancer Care
❑ The Retreat Women's Health Center
❑ Unrestricted
❑ Other Program: _____

For more information about the above funds please visit:
GoshenHealth.com/Foundation

Name: _____

Spouse's Name: _____

Address: _____

City: _____ St: _____ Zip: _____

Phone: _____

Email: _____

❑ I am a Goshen Health Colleague
❑ My spouse is a Goshen Health Colleague
❑ I prefer my gift remain anonymous
❑ I have included Goshen Health in my will.
❑ Please contact me regarding information on planned giving opportunities.

Mail this form and your gift to:

Goshen Health Foundation
PO Box 139
Goshen, IN 46527-0139