



Donation Form

Thank you so much for your generous support. Your gift will provide funds to the West Georgia Health Foundation for the benefit of West Georgia Health and the community it serves.

Donor's Name: _____

Donor's Address: _____

City, State Zip code: _____

Enclosed is my check for \$_____

Please charge my donation of \$_____ to the following credit card:

Visa Credit Card # _____

Mastercard Expiration Date: _____

American Express Signature: _____

This donation is:

In Memory of: _____

In Honor of: _____

Please include this message:

Please send acknowledgement of my gift to:

Name: _____

Address: _____

City: _____ State: _____ Zip code: _____

While keeping the amount of your donation confidential, we will send notification of your gift to you and your designated honoree or his/her family.

**Thank you for
your generous
support.**

**All gifts are tax-deductible as
allowed by law.**

Please make checks payable to:

West Georgia Health Foundation

1514 Vernon Road

LaGrange, GA 30240

706-845-3029 **Phone**

706-812-2878 **Fax**

foundation@wghealth.org **Email**