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 WellStar West Georgia Medical Center 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:

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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.

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

All donations will be allocated to our current project, the Community Cancer Center at WellStar West Georgia Medical Center.

Thank you for your generous support.

West Georgia Health Foundation
1514 Vernon Road
LaGrange, GA 30240

wellstar.org/wgmc

we believe in life well-lived.