Thank you for supporting Cincinnati Children's!

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City, State, Zip_____

Daytime Phone_____ Email_____
(We will not share your personal information with any other party.)

Are you a Cincinnati Children's employee? _____Yes _____No

GIFT INFORMATION

Gift Amount $_____

I would like my gift to support:
- ❑ Greatest Needs
- ❑ Other *(Please specify a specific program or division.)*_____

I am making my gift by:
- ❑ Check *(payable to Cincinnati Children's Hospital Medical Center)*

- ❑ Visa
- ❑ MasterCard
- ❑ Discover
- ❑ American Express

Account Number_____

Expiration Date_____

Authorized Signature_____

This contribution is*(check if applicable)***:**

- ❑ In memory of_____
- ❑ In honor of_____

Please send notification of my contribution to: *(no amount is mentioned)*

Name_____

Address_____

City, State, Zip_____

Please send your completed form to:
Cincinnati Children's Hospital Medical Center
P.O. Box 5202
Cincinnati, OH 45201-5202

For additional information, please contact Liz Curnett at 513-636-4484 or liz.curnett@cchmc.org.

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