MAIL-IN DONATION FORM

DKH DAY KIMBALL HEALTHCARE FOUNDATION

Today's hospitals and health systems are continuously evolving and Day Kimball is no exception, leading a national movement to redefine what a community hospital should be. We have the people and capabilities to deliver on that promise and are committed to delivering the highest quality healthcare close to home, using locally-based physicians, new technology and best-in-class clinical partners when you need them. This would not be possible without your support and that of our community.

Your simple act of kindness, expressed through your gift, will have a direct impact by providing vital services and compassionate care to patients and their families in their most critical time of need. To make a donation by mail, please print and mail this completed form to the address listed below.

DONOR INFORMATION

FIRST NAME/MIDDLE INITIAL/LAST NAME _____ SPOUSE/PARTNER NAME _____

COMPANY/ORGANIZATION NAME _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE _____ EMAIL _____

GIFT INFORMATION

DONATION AMOUNT (check one):

☐ $500 ☐ $250 ☐ $100 ☐ $50 ☐ $25

☐ Other Amount ($) _____

TRIBUTE my/our gift to:

☐ In honor of

☐ In memory of

☐ Please send notification of my/our gift to:

(gift amount will not be included in notification)

Name _____

Address _____

RECOGNITION PREFERENCES (check one):

☐ Please list my/our name in publications as:

_____

☐ I/We would like this gift to remain anonymous

DESIGNATE my/our gift to:

☐ Day Kimball Hospital

☐ Other* _____

Please designate your donation to one or more of the following:

- Ambulatory Care Unit
- Behavioral Health
- Birthing Center Fund
- Cardiac and Pulmonary Services
- CardioPulmonary Rehab Fund
- Emergency Department
- Family Advocacy Programs
- HomeCare Fund
- Hospice and Palliative Care of Northeastern Connecticut
- Maternal Child Care Fund
- Northeast Connecticut Cancer Fund of DKH
- Oncology - Food Pantry
- Oncology - Rose Bove LaRose Oncology Fund
- Oncology - Transportation Fund
- Orthopedic and Physical Therapy Services
- Pastoral Care Fund
- Pediatric Center Fund
- Respiratory Therapy Fund

PAYMENT TYPE (check one):

☐ Check/Money Order ☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

Credit Card Number _____ Expiration Date (mm/yy) _____ CSV _____

Cardholder Name _____

Billing Address *(if different than address above)* _____

Make checks payable to: DKH Foundation. Mail completed form and payment to:
DKH Foundation Office PO Box 632 Putnam, CT 06260