

Marshfield Clinic Donation Form

Yes, I want to make a tax-deductible gift of: \$ _____

Please use my gift for the following purpose:

- Area of Greatest Need
- Research
- Education
- Patient Care Needs
- The following purpose/fund: _____

Payment Information:

- My check payable to Marshfield Clinic is enclosed.
- Charge my credit card.
 - Visa
 - Mastercard
 - Discover
 - American Express

_____ / _____
Card Number

Expiration date

Tribute Gift (if applicable):

Gift is given *in memory* or *in honor of*: _____

Please notify _____ Relationship _____

at the following address: _____

Donor Information:

Name(s) _____ Phone _____

Organization _____ Email _____

Address _____

City _____ State _____ ZIP _____

Thank you for your gift. Your support is greatly appreciated.

Signature

Date