Community Hospital Health Foundation

_____
Donor Name

_____
Address

_____
City State Zip

_____
Phone

☐ Please list my name as above for recognition.

☐ Please list my name as follows for recognition:

_____

☐ Please do not list my name for recognition.

Mail form and payment to:

Community Hospital Health Foundation
PO Box 1328
McCook, NE 69001

Please use gift toward:

☐ the Greatest Need

☐ Hospice

☐ Endowment

☐ Equipment

☐ Scholarships

☐ Other: _____

This gift is memory / honor of:

_____

Send recognition to:

_____

_____

(Provide Name and Address)