



**California Hospital  
Medical Center Foundation**  
A member of CHW

**California Hospital Medical  
Center Foundation**  
1401 S. Grand Ave.  
Los Angeles, CA 90015  
213.742-5866 phone  
213.742-5875 fax

## Donation Form

**I would like to donate** (*circle one*): \$1,000 \$500 \$250 \$100 \$50 \$25 Other \$\_\_\_\_\_

**I would like to designate my gift to:**

- |   |   |
|---|---|
| <input type="radio"/> Use where it is most needed                         | <input type="radio"/> Hope Street Family Center           |
| <input type="radio"/> Leavey Trauma Center                                | <input type="radio"/> Donald P. Loker Cancer Center       |
| <input type="radio"/> J. Thomas McCarthy Center for Emergency Services    | <input type="radio"/> Women's and Children's Services     |
| <input type="radio"/> Los Angeles Center for Women's Health Research Fund | <input type="radio"/> Doug Augustson Memorial Scholarship |

**Donor information:**

Your Name \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Email \_\_\_\_\_ Phone \_\_\_\_\_

**If you are making this gift in memory or in honor of someone, please complete the following:**

- This donation is made (*circle one*) in memory of / in honor of: \_\_\_\_\_
- Please send gift notification to (*enter name and address*): \_\_\_\_\_
- \_\_\_\_\_

**Method of Payment:**

- I've enclosed a check payable to CHMC Foundation (*please mail your check and this form to the address above*).
- Charge my credit card:

- Visa       MasterCard       American Express

Card Number \_\_\_\_\_ Exp. Date \_\_\_\_\_

Name on Credit Card (please print) \_\_\_\_\_

Signature \_\_\_\_\_

*Gifts are tax deductible to the extent provided by law.  
California Hospital Medical Center Foundation is a 501(c)(3) nonprofit organization. Federal Tax ID: 95-4000909.*

**THANK YOU FOR YOUR SUPPORT!**