Marshfield Clinic
HEALTH SYSTEM
FOUNDATION

Lakeview Medical Center Donation Form

Today's Date: ____/____/____

Contact Information:

Name(s) _____

Organization _____ Phone _____

Address _____ Email _____

City _____ State _____ ZIP _____

Fund:

- ❑ Lakeview Medical Center Area of Greatest Need
- ❑ LMC Hospice
- ❑ Other:_____

Payment Information:

- ❑ My check payable to MCHS Foundation is enclosed.
- ❑ Charge my credit card.
  - ❑ Visa ❑ Mastercard ❑ Discover ❑ American Express

_____ _____/_____

Card Number Expiration date

Gift Amount: $ _____

Tribute Gift (if applicable):

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

Please notify _____ _____

Relationship

at the following address: _____

_____

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

_____ _____

Signature Date

Please return completed form to:
Attn: Becky Gordon, 1700 W. Stout Street, Rice Lake, WI 54868

If you have any questions, please contact us at 715-236-8233