# WOOD RIVER HEALTH'S YOUR HOME FOR HEALTH
# CAPITIAL CAMPAIGN COMMITMENT FORM

## DONOR INFORMATION *(please print or type)*

Name:_____

Billing address:_____

City, State Zip Code:_____

Phone 1:_____ Phone 2:_____

Fax:_____ Email:_____

## PLEDGE INFORMATION

I (we) pledge a total of $_____to be paid:

☐ monthly ☐ quarterly ☐ yearly/bill in month of _____

I (we) plan to make this contribution in the form of: ☐ cash ☐ check ☐ credit card ☐ other

Credit card type: _____Exp. Date:_____

Credit card number:_____

Authorized signature:_____

Gift will be matched by (company/family/foundation)_____

☐ Form enclosed in the self-addressed, stamped envelope provided ☐ Form will be forwarded

## ACKNOWLEDGMENT INFORMATION

Please use the following name(s) in all acknowledgments:_____

☐ I (we) wish to have our gift remain anonymous.

Signature(s) Date

**Please make checks, corporate matches or other gifts payable to:**
Wood River Health
823 Main Street, Hope Valley, RI 02832

**Gifts may also be made online through our secure website at WoodRiverHealth.org**