Foundation Pledge Form

Donor Information (please print or type)

Name	
Home address	
City	
State	
ZIP Code	
Telephone (home)	
Telephone (business)	
E-Mail	

Pledge Information

I (we) pledge a ***total*** of $_______________ (over 12 months) to be paid:
____ now ____ monthly ___ quarterly

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

I (we) wish to make our contribution to:
____ The Annual Fund ____ The Endowment _____ Other (will discuss with Foundation Office)

Credit card type	
Credit card number	
Expiration date	
Authorized signature	

Acknowledgement Information

Please use the following name(s) in all acknowledgements:

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

Signature(s)	Date:

Please Return to:

TRINITY HEALTH SYSTEM FOUNDATION OFFICE
380 SUMMIT AVE
STEUBENVILLE, OH 43952