Methodist HEALTH SYSTEM FOUNDATION

PLEDGE FORM

Company/donor name: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____ Phone: _____

PLEDGE

I wish to pledge $_____ in _____ payment(s) (monthly/annually),

beginning _____ (month/year).

ONE-TIME GIFT

I wish to contribute $_____ as a one-time gift.

PLEASE SEND PAYMENTS TO:
Methodist Health System Foundation
1441 N. Beckley Ave.
Dallas, TX 75203

PAYMENT

❑ My check is enclosed, payable to Methodist Health System Foundation

❑ Please charge my credit card: ❑ Visa ❑ MasterCard ❑ American Express ❑ Discover

Cardholder name: _____

Billing address (if different from above:) _____

Card number: _____ Exp. date: _____

Signature: _____ Date: _____

RECOGNITION

I would like to make this donation as a tribute gift: ❑ in honor of ❑ in memory of

Name of person you are honoring/remembering: _____

Name and address of person to notify: _____

City: _____ State: _____ Zip: _____

Recognition: _____

(Name as it will appear in recognition materials, i.e. annual report and applicable donor signage)