LEGACY HEALTH

yes! I want to make a gift!

☐ **One-time donation** $_____.00
** $5 minimum*

☐ **Check** *(Please make payable to the foundation you choose to support)*

donation options

Foundation/Medical Site	SPECIFIC PROGRAM OR AREA TO SUPPORT (OPTIONAL)	DONATION AMOUNT
☐ **CARES Northwest** - Randall Children's Hospital Foundation		$_____.00
☐ **Good Samaritan Foundation**		$_____.00
☐ **Legacy Emanuel Medical Center** - Legacy Health Foundation		$_____.00
☐ **Legacy Health Foundation**		$_____.00
☐ **Legacy Hospice Services** - Good Samaritan Foundation		$_____.00
☐ **Legacy Medical Group** - Legacy Health Foundation		$_____.00
☐ **Legacy Meridian Park Medical Center** - Legacy Health Foundation		$_____.00
☐ **Legacy Mount Hood Medical Center** - Legacy Health Foundation		$_____.00
☐ **Legacy Research Institute** - Legacy Health Foundation		$_____.00
☐ **Randall Children's Hospital Foundation**		$_____.00
☐ **Salmon Creek Hospital Foundation**		$_____.00
☐ **Silverton Hospital Foundation**		$_____.00
☐ **Unity Center for Behavioral Health** - Legacy Health Foundation		$_____.00

your information

Name _____
REQUIRED (Note: this is also how you will be listed for donor recognition purposes)

☐ **Please do not list my name publicly.**

Phone # _____ **Email** _____

tribute gift (optional)

My gift is ☐ **in honor of honor of**
☐ **in memory of**

First Name _____ **Last Name** _____

☐ **Send a letter on my behalf**

First Name _____ **Last Name** _____

Address _____

Address Line 2 _____

City _____ **State** _____ **Zip Code** _____

please mail the completed form and your check to

Legacy Health Foundation
PO Box 4500 Unit 96
Portland, OR 97208

ONFRM