Physician Giving Information

Date: _____

Donation Amount: $ _____ Directed to: *Area of Greatest Need* or _____ (choice)

Additional Information (please check as appropriate)

- ☐ Give on behalf of a company/practice: _____ (fill in name)
- ☐ Give a personal gift on behalf of me/my family
- ☐ Give anonymously
- ☐ Spouse/partner information

Recognition Name(s): _____

Comments: _____

Billing Information

Preferred Title: _____ or Suffix: _____

First Name: _____Last Name: _____

Address 1: _____

Address 2: _____

City: _____ State: _____ Zip: _____

Email: _____ Phone: _____

Payment Information (or check enclosed – circle)

Type of Card: _____

Card holders name: _____

Credit card number: _____ (to be destroyed)
Exp. Date: _____ Security Code: _____

Signature: _____ Date: _____

Please call 480.728.3931 with any questions or to securely pay over the phone or to provide more information about your gift, spouse, corporate match, or to request a tribute letter. Pay online at www.supportdignityhealtheastvalley.org. 1727 W. Frye Rd. #230, Chandler AZ 85224.

Dignity Health Foundation East Valley