

CONTRIBUTOR INDIVIDUAL BUSINESS FOUNDATION

NAME: _____

ADDRESS: _____ SUITE: _____

CITY: _____ STATE: _____ ZIP: _____

PREFERRED PHONE: _____ ALTERNATE PHONE: _____

EMAIL: _____

TYPE OF CONTRIBUTION AUCTION GIFT CERTIFICATE AUCTION ITEM PRODUCT / SERVICE

ESTIMATED VALUE OF GIFT(S): _____ EXPIRATION DATES OR RESTRICTIONS: _____

DESCRIPTION OF DONATIONS: _____

- DONATION OR GIFT CERTIFICATE ENCLOSED NEEDS TO BE PICKED UP
 WOULD LIKE HOSPITAL TO MAKE GIFT CERTIFICATE ON OUR BEHALF

The value and description of the donation is subject to change when presented in the silent auction. All information regarding the item is at the final discretion of Scottish Rite Hospital.

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I WOULD WOULD NOT LIKE MY NAME / COMPANY NAME TO APPEAR IN ALL PUBLICATIONS.

Please PRINT exactly as it should appear in promotional materials, including capitalizations and abbreviations.

SIGNATURE

SIGNATURE OF DONOR: _____ DATE: _____

Please mail this form to: