Women of Wellness Council

Dominican Hospital Foundation
A Dignity Health Member

☒ **Yes, I would like to support the Women of Wellness (WoW) Council at Dominican Hospital through an annual donation of $1,000.**

Contact Information:

Name: _____

Phone: _____ Email: _____

Address:_____ City:_____ State:_____ Zip:_____

Name as it should appear for recognition purposes (if different than above):

_____

Payment Options:

☐ I would like to have this gift remain anonymous

☐ I would like to receive my invoice on (Date) ____/____/_____ via☐ Letter☐ E-mail

☐$1,000 Payable in full ☐Initial Contribution $ _____

☐ Check enclosed, payable to **Dominican Hospital Foundation**

☐ **Credit Card Payment:**

☐ Please charge $ _____ to: ☐ VISA ☐ MC ☐ AmEx ☐ Discover

☐ Recurring Monthly Deduction of $_____ on the 1st of each month

Payment Information:

Card number: _____ Exp: _____

Name on Card: _____ CVV (3 digit code): _____

Billing Address (if different from above): _____

☐ **Payroll Deduction**: Amount $ _____ Employee ID: _____

I acknowledge this pledge is valid and will be paid in full, regardless of employment status at Dominican Hospital. **Initial** _____

Dominican Hospital Foundation is a non-profit governed under 501(c)(3) regulations Federal tax ID: 94-2450442. I/We understand that my gift is non-refundable and becomes the property of the Foundation and has ultimate control, authority, and discretion with regard to its assets. All gifts are tax deductible to the extent of the law. I/We confirm no exchange of tangible benefit or privilege in return for this donation. I/We hereby irrevocably pledge in consideration thereof the sum stated above. Our plan is to fund this gift over the aforementioned period indicated.

Signature: _____ **Date:** _____

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