**DONATION PLEDGE FORM**

**Donor Information**

|  |  |
| --- | --- |
| Name |  |
| Billing Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Telephone |  |
| Fax |  |
| E-Mail |  |

Please check here if you wish your gift to remain anonymous.

**Donation or Pledge Information**

I would like to support the Waimānalo Health Center’s mission in the following way(s):

Gift of $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Through my enclosed check payable to the **Waimānalo Health Center**

Through my credit card payment:

VISA  MasterCard  American Express

|  |  |  |  |
| --- | --- | --- | --- |
| Credit Card Number |  | | |
| Expiration Date |  | Verification Number |  |
| Authorized Signature |  | | |

Pledge of $ \_\_\_\_\_\_\_\_\_\_

To be paid:  Monthly  Quarterly  Annually

Please charge my payments directly to my credit card:

VISA  MasterCard  American Express

|  |  |  |  |
| --- | --- | --- | --- |
| Credit Card Number |  | | |
| Expiration Date |  | Verification Number |  |
| Authorized Signature |  | | |

**Special Instructions**

Please list any special acknowledgements or tributes below (optional):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please complete this form and mail it along with your gift to:

**Waimānalo Health Center**

**41-1347 Kalaniana`ole Hwy**

**Waimānalo, HI 96795**