WAIMĀNALO
HEALTH CENTER

Donation Form

Donor Information

Name/Name of Organization	
Address	
City, State Zip Code	
Telephone	
E-Mail	
Recognition Preference (please print)	

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

Donation or Pledge Information

I pledge the total sum of $_______________________________________ in support of the Waimānalo Health Center's mission.

Schedule

To be contributed: ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually ☐ One time

Contribution Method

☐ Through my enclosed check payable to the **Waimānalo Health Center**
☐ Through my credit card payment made at *waimanalohealth.org/donate*
☐ Through other assets. Please describe below:

____

____ Gift Value: $ ____________________________________

Special Instructions

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

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

Waimānalo Health Center
41-1347 Kalaniana'ole Hwy
Waimānalo, HI 96795

Phone: (808) 259-7948 Fax: (808) 259-6449
Email: development@waimanalohealth.org
waimanalohealth.org/donate

Mahalo for partnering with us to improve the health of the community!

For Accounting purposes only: ____ ID: ____________________