



Incline Village Community Hospital Foundation
880 Alder Avenue, Incline Village, NV 89451 P: 775-888-4204 or F: 530-550-5288

PLEASE PRINT

Name _____

Billing Address _____

E-Mail _____ Phone _____

Gift Allocation: IVCH Renovation Campaign IVCH Area of Most Need IVCH Medical Equipment
 Cancer Center Hospice Long Term Care Community Health (Community Health Education
 Other _____

GIFT

Enclosed is my check made payable to Incline Village Hospital Foundation for \$ _____

(or)

Please charge my Credit Card Amex, MasterCard, Visa for \$ _____

Account # _____ Exp. Date: _____

Signature _____ Date _____

(for credit card authorization only)

Memorial or Tribute Information:

This donation is made in Memory/Honor of: _____

Please send an acknowledgement to (name and address) _____

PLEDGE

Total Pledge Amount \$ _____

Pledge Terms - I would like to make my pledge in payments as follows:

\$ _____ In One Payment This Year

\$ _____ In Payments Over Two Years beginning _____ and ending _____ (year)

\$ _____ In Payments Over Three Years beginning _____ and ending _____ (year)

\$ _____ In Payments Over Five Years beginning _____ and ending _____ (year)

_____ Date _____

Pledge Signature and Date

Your gift is tax deductible to the full extent allowed by law. In accordance with IRS reporting requirements, no goods or services were provided to you in consideration of your contribution.

*Our Federal Tax ID is 20-0752156 **Please keep this letter as a receipt for tax purposes.***