ST. JOHN'S EPISCOPAL HOSPITAL
EPISCOPAL HEALTH SERVICES INC.

Annual Campaign
Gift Form

Gift Information:

Yes, I am pleased to support St. John's with the enclosed gift of: _____ Date _____

This is a: ❑ One-time gift ❑ Monthly gift (I authorize St. John's to charge the amount above to my account each month. Please process on the ❑ 1st or ❑ 15th)

❑ I have enclosed a Check *(payable to St. John's Episcopal Hospital)*

❑ Please Charge my: ❑ VISA ❑ AMEX ❑ Mastercard ❑ Discover

Card # _____ Sec. Code _____ Exp. Date _____

Name on Card _____ Signature_____

Donor Information:

Name _____

Home Address _____

City, State, Zip _____

Preferred Phone _____ Preferred Email: _____
(Home/Business/Cell) *(Home/Business)*

❑ I would like to learn more about planned giving ❑ I have included a gift in my Will or other legacy plans.

Please sign and date this form

_____ _____
Donor Signature Date

Questions on giving or how to get involved in our events? Please call (516) 349-5257

Send completed form by email (scan) or regular mail:

St. John's Episcopal Hospital
700 Hicksville Road
Bethpage, New York 11714
Attention: Nancy Leghart, Director of Foundation

Email: nleghart@ehs.org