SSM Health | St. Mary's Foundation MADISON

**Please designate my gift for:**

❍ Hospital Greatest Need

❍ Other _____

**I support SSM Health St. Mary's Foundation with the following:**

❍ One-time Gift or

❍ Recurring Gift: ____ Weekly ____ Monthly ____ Quarterly ____ Annually

**Gift amount:** ❍ $50 ❍ $100 ❍ $250 ❍ $500 ❍ Other $ _____

❍ $1,000 Leadership Circle Giving Level

**Payment Options:**

❍ Credit card ❍ Check (*Payable to St. Mary's Foundation – Madison)*

Card #_____Exp. Date _____

3-digit Security Code _____ Signature _____

**Your Contact Information:**

Name(s) _____

Street _____

City_____State_____ZIP_____

Phone_____Email_____

Donor Recognition Name _____

❍ I wish to remain anonymous.

**Optional Tribute Details:** ❍In Memory of ***or*** ❍In Living Tribute to:

Name _____

*Send an acknowledgment of my tribute to:*

Name _____

Address _____

City_____State_____ZIP_____

**Mail gift with completed form to:**

SSM Health St. Mary's Foundation
700 South Park Street, Madison, WI 53715

Phone: 608-258-5600 Fax: 608-229-8495
Email: stmarysfoundation@ssmhealth.com

**For more information or to make a gift online visit:**
**ssmhealth.com/stmarysfoundation**