Swedish Hospital Foundation

Donation Form

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Email: _____

Please designate my gift to the following fund:

- ☐ Pathways for Survivors of DV, SA, and HT
- ☐ COVID-19 Relief
- ☐ Dentistry
- ☐ Women's Health
- ☐ Cancer Survivorship
- ☐ Nursing
- ☐ Helping Hands
- ☐ Galter LifeCenter
- ☐ Employee Benevolence
- ☐ Greatest Need
- ☐ Other _____

☐ **Check**: I have enclosed my check in the amount of $_____ made payable to Swedish Hospital Foundation.

☐ **Credit Card**: Please charge the following credit card in the amount of $_____

- ☐ Visa
- ☐ Discover
- ☐ MasterCard

Credit Card #: _____

Expiration Date: _____ Security Code: _____

Other Giving Options:

- ☐ Please provide instructions for the transfer of securities.
- ☐ I have included Swedish Hospital Foundation in my estate plans.

I would like to be recognized as _____

☐ I wish for my gift to be anonymous.

Signature: _____ Date: _____

Please email this form to **schfoundation@schosp.org** or mail to: Swedish Hospital Foundation, 5145 N. California Avenue, Chicago, IL 60625

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