



CaroMont Health Foundation

Donation Form

Name(s) _____

Billing Address _____

City _____ State _____ Zip Code _____

Phone _____ Email _____

My gift to support the CaroMont Health Foundation:

- \$50
- \$100
- \$250
- \$500
- \$1,000
- Other _____

Payment Information:

- Check

Please make your tax-deductible contribution payable to:

CaroMont Health Foundation
 Attn: Mary Grace Bean
 2525 Court Drive
 Gastonia, NC 28054

- Credit or Debit Card

Card Number _____

Expiration Month and Year _____ CVC/CSC _____

Authorizing Signature _____

Gift Designation:

- Fund or Cause

I would like my donation to support the following fund or cause: _____

- In honor or memory of (please circle): _____

Please send an acknowledgement of my gift to:

Name _____

Address _____

City _____ State _____ Zip Code _____

Please contact the CaroMont Health Foundation if you have any questions at (704) 834-4034 or foundation@caromonthhealth.org.