Rockingham Health Care Foundation
Donor Form

Donor Information
Preferred Title (circle one) Dr. Mr. Mrs. Ms. Miss Other ________________________
Name ____

If your gift is a company or corporate gift, please complete the following section. If not, skip to Address.
Company Information
Company ____
Contact Person ____
Title ____

Address Information
Address ____
City ____
State/Province ____
Zip/Postal Code ______________________________ Country ___________________
Phone _________ – _________ – ________________
E-Mail Address ____

Gift Amount
I would like to make a gift of $__________

Method of Payment
____ I have enclosed a check in the amount of $ ___________________
Please make check payable to **Rockingham Health Care Foundation.**

____ Mastercard ____ Visa ____ Discover

Card Number ____
Exp. Date _______________ Name on Card __________________________________
Signature ____

(continued on back)

Gift Designation Options**

I would like my/our contribution to benefit (check one)

___ The hospital's most pressing needs
___ 2019/2020 Giving Campaign to enhance cardiology services
___ Cancer Assistance Fund
___ UNC Rockingham Health Care Rehabilitation and Skilled Nursing Care Center
___ Other ____

**If no designation is selected, your gift will be applied to the hospital's most pressing needs. If you have additional questions about donation options, please call the Foundation office at 336-627-8510.

Recognition Preference

Please list my/our name in donor recognition material as:

____

___ I/we would like this gift to remain anonymous.

Honor/Memorial Giving (optional)

Select one

___ I would like to dedicate my gift in **memory** of ___________________________.
Please note any special relationship to this person or occasion you would like acknowledged. ____.

___ I would like to dedicate my gift in **honor** of _____________________________.
Please note any special relationship to this person or occasion you would like acknowledged. ____.

Notification Information for Honor/Memorial Giving:

*The amount of the gift will not be disclosed.

Name ____
Address ____
City ____
State/Province ____
Zip/Postal Code _______________________ Country _________________

Please return this completed donation form to:
Rockingham Health Care Foundation
117 East Kings Highway
Eden, NC 27288

or fax to: 336-623-7560

or email to: RockinghamFoundation@unchealth.unc.edu