Growing for You

Behavioral Health & Emergency Medicine

The Foundation
Sheridan Memorial Hospital
PO Box 391 Sheridan, WY 82801 307.673.2418

Name(s): ______________________________
Print your family or corporate name as you would like it to appear in Foundation publications

☐ Please check here if you wish to remain anonymous

Mailing Address: ______________________________

E-Mail Address: ______________________________

Phone: ______________________________

Payment Options:

Cash Gift

One time gift of: $ ____________ to be paid on date: ____________

Pledge Gift

My total pledge is: $ ____________ Beginning on: ________/________
Month *Year*

To be paid over: ______ years, with installments of: $ ____________

☐ *Annually* ☐ *Quarterly* ☐ *Monthly* ☐ *Other:* ____________

☐ Reminders sent at interval determined above ☐ Card charged at interval determined above *(enter card details below)*

5 Year Pledge Option Examples

Pledge Amount	Annual Payment
$250	$50/yr
$500	$100/yr
$1,000	$200/yr
$2,500	$500/yr
$5,000	$1,000/yr
$10,000	$2,000/yr

Payment Information:

☐ Check ☐ Cash ☐ Charge

Made payable to: SMH Foundation

Name on Card: ____________

Account #: ____________

Exp. Date: ________ *Auth Code:* ________

☐ This gift is in Honor of or in Memory of: ____________
(circle one) *(Name)*

Donor/Primary Gift Contact:

Printed Name(s): ______________________________

Signature: ______________________________ Date: ____________

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