



## Donation Form

### Donor Information (please print or type)

Name:				
Address:				
City:	State:	ZIP Code:		
Telephone:				
E-Mail:				

### Gift Information

I (we) would like to support Beth Israel Deaconess Medical Center with a gift of

\$25       \$50       \$100       Other \$ \_\_\_\_\_

I (we) would like to designate my (our) gift to the following fund:

Annual Fund       Other: \_\_\_\_\_

### Payment Information

Enclosed is a check payable to Beth Israel Deaconess Medical Center

I (we) wish to charge my (our) gift to:       Visa       MasterCard       American Express

Credit card number:	Exp. Date:
Exact Name on Card:	
Authorized signature:	
Security Code*:	

\* For Mastercard, Visa and Discover: 3-digit code on the back of the card; for American Express, 4-digit code on the front of the card.

### Tribute Information

My (our) gift is       In Honor of       In Memory of       In Celebration of

Name(s):	
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Please send notification to: *(The amount of your gift will not be forwarded with the notification.)*

Name:				
Address:				
City:	State:	ZIP Code:		

### Please return your gift and this form to:

Office of Development  
Beth Israel Deaconess Medical Center  
330 Brookline Avenue (BR)  
Boston, MA 02215  
617-667-7330 / 617-667-7340 (fax)

- Enclosed in a matching gift form from: \_\_\_\_\_
- I have included BIDMC in my will or trust.
- I would like more information about including BIDMC in my will or trust.
- Send me information about gifts to BIDMC that provide lifetime income to me.

**Thank you for your generous support!**