

**St. John West Shore Hospital
Donation Form**

Donor Information

First Name: _____ M.I.: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ (Please include area code)

Business Phone: _____ (Please include area code)

E-Mail Address: _____

Gift Amount & Payment Information

I am enclosing a check in the amount of: \$ _____

I would like to make a financial contribution using my: (please select one):

___ Visa ___ Mastercard

Name as it appears on card: _____

Credit Card Number: _____ Expiration Date: _____

Memorial/Tribute Information

Gift Type: (please select one) ___ Memorial ___ Tribute

My Gift is in memory/honor of:

First Name: _____ MI: ___ Last Name: _____

At your request, we will send an acknowledgement letter to the family or friend in whose name this gift was made.

Please provide their information below:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Please make checks payable to:

St. John Medical Center
Administration
29000 Center Ridge Road
Westlake, Ohio 44145