Wisconsin Women's Health Foundation
Donation Form

YES! I want to make a difference in the health of Wisconsin women.

Please accept my/our gift of $_____.

Please use my gift for:

☐ Greatest area of need

☐ Research/Grants

☐ Education, prevent & outreach

Donor(s):_____

Please print name as you prefer it to appear in our publications. ☐ Check here if anonymous.

Address: _____

City, State, Zip: _____

Phone, Fax, Cell: _____

Email: _____

Please let us know:

☐ Name change

☐ Address change

Payment Schedule:

$_____Initial payment enclosed, then:

$_____Annually for ___ years

$_____Quarterly for ___ years

$_____Semi-annually for ___ years

$_____Monthly for ___ months

$_____One-time gift

Your gift may be made in recognition or remembrance. Please print name as you would like it to appear on the certificate WWHF will send.

☐ In Honor of:_____

☐ In Memory of: _____

Please send the *In Honor/Memory of* certificate to:

Name:_____

Address:_____

City, State, Zip:_____

Payment Method:

☐ Cash

☐ Check enclosed – payable to WWHF

☐ Charge my credit card ☐ Visa ☐ MasterCard

Credit Card #

Exp. Date 3-Digit Security Code

Signature

The Wisconsin Women's Health Foundation is a 501(c)(3) tax-exempt organization. All contributions are 100% tax deductible to the extent permitted by law.

Please Mail or Fax this Donation Form to:
Wisconsin Women's Health Foundation
2503 Todd Drive, Madison, WI 53713
800.448.5148 | 608.251.4136 (FAX)
www.wwhf.org