

Thank you for supporting Cincinnati Children's!

Name _____

Address _____

City, State, Zip _____

Daytime Phone _____ Email _____

(We will not share your personal information with any other party.)

Are you a Cincinnati Children's employee? _____ Yes _____ No

GIFT INFORMATION

Gift Amount \$ _____

I would like my gift to support:

- Greatest Needs
- Other *(Please specify a specific program or division.)* _____ The Olivia V. Erhardt Fund for SURF - The LO.V.E. Fund

I am making my gift by:

- Check *(payable to Cincinnati Children's Hospital Medical Center)*
- Visa Account Number _____
- MasterCard
- Discover Expiration Date _____
- American Express
- Authorized Signature _____

This contribution is *(check if applicable)*:

- In memory of _____
- In honor of _____

Please send notification of my contribution to: *(no amount is mentioned)*

Name _____

Address _____

City, State, Zip _____

Please send your completed form to:

Cincinnati Children's Hospital Medical Center
P.O. Box 5202
Cincinnati, OH 45201-5202

For additional information, please contact Liz Curnett at 513-636-4484 or liz.curnett@cchmc.org.

