

# MILE BLUFF MEDICAL CENTER FOUNDATION - DONATION FORM

**CONTRIBUTION INFORMATION** - Please choose from the options below. All gifts are tax-deductible. Thank you!

- ☐ Contribution of \$\_\_\_\_\_
- ☐ cash (submit with form)
  - ☐ check (payable to Mile Bluff Medical Center Foundation, submit with form)
  - ☐ credit card (to pay online, visit [www.milebluff.com/donate](http://www.milebluff.com/donate))

**OPTIONAL INFORMATION** - Please fill out any of the items below that pertain to your contribution.

☐ I would like my gift to be used for

- |  |  |
|--|--|
| <input type="checkbox"/> Area of greatest need | <input type="checkbox"/> Building improvements |
| <input type="checkbox"/> Equipment             | <input type="checkbox"/> Scholarships          |
| <input type="checkbox"/> Other: _____          |  |

☐ My contribution is made:

☐ In memory of

Name of individual: \_\_\_\_\_ Relationship to you: \_\_\_\_\_

☐ In honor of

Name of individual: \_\_\_\_\_ Relationship to you: \_\_\_\_\_

☐ Please notify (optional)\*

Name \_\_\_\_\_

Relationship to person being honored/memorialized: \_\_\_\_\_

Address \_\_\_\_\_

*\*Amount of gift is kept confidential*

**DONATION AUTHORIZATION** - This section must be completed before returning. Please print your name the way you would like it to appear in future promotion of the foundation and this program. If you prefer to remain anonymous, please check here.

☐ I want my gift to be anonymous.

Name \_\_\_\_\_

Home address \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Email \_\_\_\_\_ ☐ I would like to receive updates from the foundation.

**PLEASE SEND COMPLETED FORM WITH DONATION TO**

Mile Bluff Medical Center Foundation | 1050 Division Street | Mauston, WI 53948



**THANK YOU FOR SUPPORTING  
THE HEALTH OF OUR COMMUNITY!**

Mile Bluff Medical Center Foundation is a 501(c)(3) nonprofit organization. All donations are tax-deductible.

**SCAN TO GIVE ONLINE**

