Jackson Health FOUNDATION

DONATION FORM

Support the Foundation

Your generosity is what makes healing possible for thousands of families in Miami-Dade County and beyond. Take the next step and add your support to that of your friends and visionary donors. Through the Jackson Health Foundation, you may designate gifts to a specific program or fund, and gifts can be made in remembrance to honor a friend or loved one. Your gift can make a real difference in the lives of our patients.

Donation Amount

Select the amount of your donation below:

_____ $25
_____ $50
_____ $100
_____ $500
_____ Other (Specify Amount: $_____)

Designation

Specify where you would like your donation to go.

_____ Where it is Needed Most
_____ Women and Babies Hospital
_____ GUA Membership
_____ JHF Miracle Fund
_____ Other (Specify Designation: _____)

Tribute Gift

This gift is in honor, memory, or support of someone.

_____ In honor of
_____ In memory of
_____ Person's Name (_____)
_____ Please notify the following person of my gift
- Specify Name: (_____)

Billing Address

Name: _____
E-Mail: _____
Phone: _____
Country: _____
Address: _____
City: _____
Zip: _____

Payment Details

Cardholder Name: _____
Card Number: _____
Expiration Date: _____
Card Security Code (CSC): _____
Cardholder Signature: _____

I authorize Jackson Health Foundation to charge the credit card indicated on this form, for the noted amount on today's date. This payment is for a charitable donation. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company, so long as the transaction corresponds to the terms indicated on this form.