St. Lawrence Health System
Canton-Potsdam Hospital Foundation

Personal Information	*Gift Information*
Name ___________________________________	_____ ***President's Honor Society - $2,500***
Address ________________________________	_____ ***President's Circle - $1,000***
City, State, Zip _________________________	_____ ***Founder - $500***
Phone __________________________________	_____ ***Leader - $250***
Email ___________________________________	_____ ***Member - $100***
	_____ ***Associate – Under $100***
	I wish to make a gift in the amount of $______
	☐ ***My check is enclosed.***
	☐ ***Charge my credit card** $_________________*
☐ *Please send me information about monthly giving via credit card or checking.*	*Card Number________________________________*
	Expiration Date_________ Security Code_________
☐ *Please send me information about including the Hospital Foundation in my will.*	*Signature ___________________________________*
	☐ Please use my gift wherever it is needed most.
	☐ Please restrict my gift for: __________________
	☐ I wish to make this gift anonymously.
Please return completed form to: **Canton-Potsdam Hospital Foundation** **50 Leroy Street** **Potsdam, New York 13676** Questions? Contact Barbara Burcume 261-5414 bburcume@cphospital.org	☐ This gift is in memory of: ___________________________________ Please notify ___________________________ ☐ This gift is in honor of: ___________________________________ Please notify ___________________________