TWICE BLESSED DONATION FORM

Please complete the information below to ensure proper preparation.
(please print clearly)

Donor Name: _____

Organization Name (if applicable)**:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Country: _____

Email (optional)**:** _____

Telephone Number (optional)**:** _____ ☐Home ☐Mobile

THANK YOU FOR YOUR DONATION

Please mail to:
St. Joseph's Community Health Foundation
308 2nd Ave SW, Minot, ND 58701
Email: sjchf@minot.com

If you would like to donate by phone via credit card, please call (701) 837-1726.

METHOD OF PAYMENT

Check or money order
(please make payable to St. Joseph's Community Health Foundation and enclose with form)

Credit Card: Visa / Mastercard (please circle)
(credit card payments are subject to a 3% surcharge)

☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Expiration Date: _____

Cardholder's Name: _____

Signature: _____

Date: _____

Amount of Donation: $ _____

☐ Please add the 3% surcharge to my gift.

CAUSE

To donate to a specific cause, please write the name of the cause on the memo line of your check. For credit card donations, please indicate here the cause you would like your donation and the **TWICE BLESSED** matched donation to go to.

Name of Cause: Heart of America Medical Center - Rugby