

Mail-in Donation Form

Return To: Bridgeport Hospital Foundation
267 Grant Street
Bridgeport, CT 06610



Name _____

Address _____

City/State/Zip _____

Phone _____

E-mail Address _____

Gift Amount: \$ _____ Program Designation: _____

Method of Payment:

- Check Please make checks payable to **Bridgeport Hospital Foundation.**
- Credit Card Amex MC VISA Discover

Card Number _____ CVV Number _____

Signature _____ Exp. Date _____

Billing Address (if different from mailing address: _____

This gift is made *In memory of* *In honor of*

Name _____

Please send acknowledgement to:

Name _____

Address _____

City/State/Zip _____

- I prefer to make this donation anonymously.

Please send me information about:

- Gifts that will pay me an income for life.
- Giving through my will.
- Volunteer opportunities.
- I have included Bridgeport Hospital in my estate planning.