Donation Form

Please print and complete this form to make a gift to Children's Healthcare of Atlanta

Your name as you wish it to appear in printed material: ____

Company name (if corporate gift):____

Address:____

City:________________________ State:_______ Zip:______________

Daytime phone: ________________________________ E-mail:_____________________________

I would like to support Children's Healthcare of Atlanta with a gift of $_____________________

____Check enclosed ____ AMEX ____ MasterCard ____Visa ____Discover

Credit card number: ____Exp. Date: ____________

Name on credit card: ______________________________________ CVV No.: _____________

Signature (required for all credit card charges):____

I would like my gift to support:____

If your employer will match your gift, please enclose completed form

Tribute gift (circle one): My gift is in honor or memory of: __________________________________

Pleasenotify (name):____

Address:____

City: ______________________ State: _____ Zip:_______________

Please mail this form along with your donation to:
ATTN: Children's Healthcare of Atlanta
1577 Northeast Expressway, Suite A
Atlanta, GA 30329
For questions, please call 404-785-7539

______ I would like to receive information about including Children's in my will or estate plan

Dedicated to All Better℠