



NAME _____

HOME ADDRESS _____ CITY/STATE/ZIP _____

HOME PHONE _____

E-MAIL _____

Gift Information

Enclosed is my gift of: \$ _____

My check is enclosed payable to:

- Sutter Amador Hospital Foundation
- Sutter Auburn Faith Hospital Foundation
- Sutter Davis Hospital Foundation
- Sutter Medical Center Foundation
- Sutter Medical Foundation
- Sutter Roseville Medical Center Foundation
- Sutter Solano Charitable Foundation

*The amount of your gift is confidential.
All gifts are tax-deductible.*

We are grateful for the support we receive from our friends in the community. If you prefer not to receive fundraising information from us, please call us at (916) 733-3863 or email us at shssrphil@sutterhealth.org, and we will remove your name from our list. Please allow at least four weeks to process your request.

Please return this form with your gift to:

SHSSR Philanthropy Office
2800 L Street, Suite 620
Sacramento, CA 95816
(916) 733-3863

Please charge my gift:

- VISA MasterCard AmEx

NAME ON CREDIT CARD _____

CARD # _____

SECURITY CODE _____ EXP. DATE _____

SIGNATURE _____

PHONE _____

EMAIL _____

You may add an appreciation note to your doctor on the reverse side.

- Please check here if we may not use your written comments for public recognition of our physicians and staff. Your name will be kept confidential.





Please let us know who you wish to honor and why. We'll send a Doctor's Day certificate to each one conveying your gratitude, without mentioning the amount of your gift. *Thank you.*

I celebrate and honor

(Physician's first and last name—please print)

because _____

Physician's address: _____
..... (Address/City/Zip)

Please send certificate to my doctor from _____
(Your first and last name)

I celebrate and honor

(Physician's first and last name—please print)

because _____

Physician's address: _____
..... (Address/City/Zip)

Please send certificate to my doctor from _____
(Your first and last name)

I celebrate and honor

(Physician's first and last name—please print)

because _____

Physician's address: _____
..... (Address/City/Zip)

Please send certificate to my doctor from _____
(Your first and last name)