



Sequoia Hospital Foundation

# Contribution Form

Please print and complete this form and return it to our office by mail or fax.

**Sequoia Hospital Foundation**  
170 Alameda de las Pulgas Redwood City, CA 94062  
fax (650) 369-0277

*If you have any questions, please call our office at (650) 367-5657*

## Your name:

First: \_\_\_\_\_ Middle initial: \_\_\_\_\_ Last: \_\_\_\_\_

## Contact Information:

Street address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Day phone: \_\_\_\_\_ Evening phone: \_\_\_\_\_

Email: \_\_\_\_\_ Fax: \_\_\_\_\_

## Gift Information:

Amount: \_\_\_\_\_

- Please apply my gift where Sequoia Hospital's need is the greatest  
 Please restrict my gift to (service or fund at Sequoia Hospital): \_\_\_\_\_

## Payment Information:

Credit card type: (circle one)      Visa              Mastercard              American Express

Credit card number: \_\_\_\_\_ Expiration date: \_\_\_\_\_

Cardholder's name: \_\_\_\_\_

Street address on credit card: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Signature: \_\_\_\_\_



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## Gifts in Tribute:

- This gift is in memory of: \_\_\_\_\_
- This gift is in honor of: \_\_\_\_\_
- I am a former patient and am naming \_\_\_\_\_  
as my Sequoia Hospital Guardian Angel. (*Guardian Angels must be physicians or employees at Sequoia Hospital.*)

Please notify the following individual/family that a gift in tribute has been received:

Name: \_\_\_\_\_

Street address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## Other Information:

- I would prefer that my gift remain anonymous.
- Please contact me about planned giving opportunities.
- Please do not email me.

*Thank you for your support.  
Your contribution helps to assure that Sequoia Hospital is able to deliver the world-class,  
award-winning health care that is our hallmark.*