

**NEVADA REGIONAL MEDICAL CENTER FOUNDATION**  
**Printable Donation Form**

Please complete this form and mail along with your donation to:

**NRMC Foundation**  
**800 S. Ash**  
**Nevada, MO 64772**

Or FAX it to us at: (417) 448-3848

(Please check one):     Mr.     Mrs.     Ms.     Miss     Dr.

**First Name:** \_\_\_\_\_ **Last Name:** \_\_\_\_\_

**Street Address:** \_\_\_\_\_

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

**Home Phone:** \_\_\_\_\_ **Business Phone:** \_\_\_\_\_

**Fax:** \_\_\_\_\_ **E-mail:** \_\_\_\_\_

**Donation Amount:** \$ \_\_\_\_\_

Memorial\*     Honor\*    \*Notification of your gift is sent immediately. The amount is kept confidential.

If you are making an Honorary Gift, please indicate the occasion or reason for your donation:

Birthday     Anniversary     Other \_\_\_\_\_

Memorial/Honor Name: \_\_\_\_\_

Please Notify: \_\_\_\_\_

Address: \_\_\_\_\_

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

**Method of Payment: (please check one)**

Enclosed is a check. (make payable to NRMC Foundation)

Credit Card:     Visa                       MasterCard             Discover

**Credit Card Number:** \_\_\_\_\_ **Expiration Date:** \_\_\_\_\_

**Cardholder's Name (printed):** \_\_\_\_\_

**Cardholder's Signature:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_

An acknowledgment will be mailed to you upon receipt of your gift.

**THANK YOU FOR YOUR DONATION!**

Contributions to the NRMC Foundation are tax-deductible as allowed by law.