



**Thank you!** Your gift to Emory Healthcare is greatly appreciated and will help ensure that Emory continues to be a leader in providing outstanding patient- and family-centered care.

Please complete the following information, print this form, and mail with your check or credit card information to the address below. Please make checks payable to Emory.

**Salutation:**  Mr.  Ms.  Mrs.  Mr. & Mrs.  Miss  Dr.

Name (as it appears on card) \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Phone \_\_\_\_\_ Phone Type  Business  Home  Mobile

Email Address \_\_\_\_\_

Check one  MC  Visa  American Express

Amount of Donation: \_\_\_\_\_ Credit Card # \_\_\_\_\_ Exp: \_\_\_\_\_

**Designate my gift to the following:**

**Emory Healthcare**

- Wherever the need is greatest - Emory Healthcare Partners in Health
- Patient- and Family-Centered Care Support Initiatives
- Pastoral Services
- Clinical Quality and Patient Safety Initiatives
- Nursing Continuing Education
- Employee Continuing Education

**Emory Clinic**

- Fund for Excellence

**Emory Johns Creek Hospital**

- Fund for Excellence

**Emory Saint Joseph's Hospital**

- Emory Saint Joseph's Hospital Fund

**Other**

\_\_\_\_\_

Please keep my gift anonymous

**Emory University Hospital**

- Fund for Excellence

**Emory University Hospital Midtown**

- Fund for Excellence

**Emory University Orthopaedics and Spine Hospital**

- Fund for Excellence

**Emory Wesley Woods Center**

- Fund for Excellence

**Emory Brain Health Center**

- Director's Fund

**Winship Cancer Institute of Emory University**

- Director's Fund

MAIL TO:  
MSC 0970-001-8AA  
Office of Gift Records  
Emory Healthcare  
1762 Clifton Road, NE Suite 1400  
Atlanta, GA 30322-4001

*If you have any questions or would like to make a gift by phone, please call 404.727.9503.  
Gifts to Emory Healthcare are charitable to the fullest extent of the law.*

*Thank you for your support of Emory Healthcare!*

**Honor/Memorial Giving**

**My gift is: (please choose)    In honor of    In memory of**

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

**Honoree of Next of Kin Information**

*We will send a letter acknowledging your gift to the person of your choosing. This can be the honoree, next of kin for a memorial donation, or someone else. Please fill in the recipient's information below.*

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

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

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

**Matching Gift**

More than 500 companies will match or multiply donations made by their employees. Does your employer (or spouse's or partner's employer) have a matching gift program? If so, please remember to submit your request to your company to have your gift to Emory Healthcare matched.

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