

Donation Form

Thank you for supporting USC Arcadia Hospital by making a tax-deductible donation.

DONOR INFORMATION

First and Last Name : _____

Street Address : _____ City: _____

State: _____ Zip code: _____ Email: _____ Phone: _____

GIFT INFORMATION

Please select your preferred giving method:

Credit Card

My total gift amount*: \$83.34 per month (\$1,000.08/year) \$2,500
 \$1,000 \$_____

Donors whose gifts accumulate to \$1,000 or more in a calendar year will be recognized in our **Partners in Health annual giving society.*

Type of credit / debit card: VISA Mastercard AMEX Discover

Credit card #: _____ Exp. date: _____ CVV: _____

Same as name and mailing address above.

Name on card: _____ Address: _____

City: _____ State: _____ Zip code: _____

Check

Please make payable to "USC Arcadia Hospital Foundation"

Enclosed is a check for my one-time gift of \$_____

My area of support:

Greatest Need Cardiac Care
 Emergency Services Maternal Child Health
 Stroke Care Other: _____

My gift is a tribute gift:

In honor of: _____
 In memory of: _____

Select any donor committees you are a part of (if applicable):

Asian Outreach
 Latino Outreach

COMPLETE YOUR GIFT

Please mail your completed form (with check if applicable) to:

USC Arcadia Hospital Foundation
300 W. Huntington Drive
Arcadia, CA 91007

Questions?

Please contact Maggie Trigueros, Director of Annual Giving at maggie.trigueros@med.usc.edu or 626.821.2312
USC Arcadia Hospital Foundation Tax ID # 95-3407027.