Yes! I'd like to donate To Lamprey Health Care.

SELECT DONATION AMOUNT:

❒ $25.00 ❒ $100.00 ❒ $1,000.00
❒ $50.00 ❒ $250.00 ❒ $2,500.00
❒ $75.00 ❒ $500.00
❒ OTHER AMOUNT: $_____

TYPE OF DONATION: ❒ ONE TIME DONATION ❒ RECURRING DONATION

YOUR CONTACT INFORMATION:

TITLE: ❒ MR. ❒ MRS. ❒ MS. ❒ MR.&MRS.

FIRST NAME: _____

MIDDLE NAME: _____

LAST NAME: _____

STREET 1: _____

CITY/STATE/ZIPCODE: _____

COUNTRY: _____

TELEPHONE: [_____] _____

E-MAIL ADDRESS: _____

❒ *Yes, I would like to receive communications from your organization.*

PAYMENT INFORMATION:

CREDIT CARD TYPE: ❒ VISA ❒ MasterCard ❒ DISCOVER ❒ AMERICAN EXPRESS

CREDIT CARD #: _____ EXP. DATE: _____

CSC (CARD SECURITY CODE) *(The 3- or 4-digit number printed on your credit card)* _____

❒ CHECK THIS BOX TO USE THE SAME NAME AND ADDRESS AS YOUR CONTACT INFORMATION.

CARDHOLDER'S NAME: _____

CARDHOLDER'S ADDRESS: _____

_____

CITY / STATE / ZIPCODE: _____

DONATION PREFERENCE: By making your gift undesignated, we will determine where your donation can have the greatest impact. If you have preferences for the allocation of your donation, you may select a category below.

❒ UNDESIGNATED ❒ CAPITAL DEVELOPMENT FUND

GIFT TYPE: Select the type of donation you would like to make below:

❒ GENERAL DONATION: *Support Lamprey Health Care's mission where it is needed most.*
❒ MEMORIAL GIFT: *Celebrate the memory of a loved one by giving a gift that shares hope for a better future.*
❒ HONOR GIFT: *Commemorate a special person, holiday, birthday, wedding, or other special occasion.*

MAIL YOUR GIFT TO:

Director of Development
Lamprey Health Care
207 South Main Street, Newmarket, NH 03857
603-659-3106
www.lampreyhealth.org

LAMPREY HEALTH CARE
Where Excellence and Caring go Hand in Hand