

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:    
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