



**Yes, I want to help support St. John's healthcare mission.**

I would like to contribute:  \$25  \$50  \$100  \$500 Other Gift: \_\_\_\_\_

Please designate my gift to: \_\_\_\_\_  
(optional)

I've enclosed my check payable to Friends of St. John's Hospital

Charge my contribution to my:  Discover  VISA  MasterCard  American Express

Card # \_\_\_\_\_ Exp. Date \_\_\_\_\_

Name on card \_\_\_\_\_

Optional:

In honor of: \_\_\_\_\_

In memory of: \_\_\_\_\_

To honor the: \_\_\_\_\_  
(occasion)

of \_\_\_\_\_  
(honoree)

**My gift is in appreciation of my Guardian Angel health care provider/staff member at St. John's Hospital.**

\_\_\_\_\_  
(Staff member's name)

\_\_\_\_\_  
(St. John's facility and department) Date of service (if known)

**Please feel free to enclose a note to your Guardian Angel. We will be happy to pass along your kind words.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Your Guardian Angel will be notified of your special tribute gift. Gift amounts remain confidential.**

**Please print your name as you would like it to appear in our donor report.**

Name \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_

**Please send an acknowledgment of my gift to:**

Name \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_

**Please complete and return this form with your contribution to:**  
Friends of St. John's Hospital  
800 East Carpenter St.  
Springfield, IL 62769

**St. John's Hospital provides a ministry of exceptional health care services to the people of central Illinois in the Catholic tradition of compassion, justice, and reverence for life.**