

Yes, I want to help support St. John's healthcare mission. Please direct my gift to:

Endowment Where the need is greatest Other _____
.....

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 _____

Signature _____

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

Name _____

Address _____

City _____ State _____ Zip Code _____

Optional:

• In honor of _____

• In memory of _____

• To honor the _____

(occasion)

of _____

(honoree)

Please send an acknowledgment of my gift to:

Name _____

Address _____

City _____

State _____ Zip Code _____

Mail this form with payment to:

Friends of St. John's Hospital

800 E. Carpenter Street

Springfield, IL 62769