Donate to Children’s Hospital of Wisconsin

To mail in your donation, please:

1) Print out this form
2) Fill out the form
3) Mail it, along with your check (if you are not paying by credit card) to the following address:

Children's Hospital of Wisconsin Foundation
MS 3050
P.O. Box 1997
Milwaukee, WI 53201

Please select a donation amount:

- $50.00
- $100.00
- $250.00
- $500.00
- $2,000.00
- Other amount: [ ]

Gift type:

- One-time gift
- Recurring gift
  If recurring, please fill out the following info:
    - Monthly
      For how long? _____
    - Annually
      For how long? _____

- Yes, I would like to make this donation anonymously

Please continue to the next page.
☐ Yes, this is an honor or memorial gift

**Honor gift type:**

☐ In Memory of  ☐ In Honor of

Honoree name: __________________________________________________________

Notification recipient name: _____________________________________________

Notification recipient street 1: __________________________________________

Notification recipient street 2: __________________________________________

Notification recipient city: _____________________________________________

Notification recipient State: ____________________________________________

Notification recipient ZIP: ______________________________________________

**Estate planning:**

☐ Yes, I have already included Children’s in my estate plan.

☐ Yes, I would like information on supporting Children’s after my lifetime.

**Billing information:**

First name: ____________________________________________________________

Last name: _____________________________________________________________

Street address 1: ______________________________________________________

Street address 2: ______________________________________________________

City: _________________________________________________________________

State/province: ________________________________________________________

*Please continue to the next page.*
ZIP/postal code: ____________________________________________
County: __________________________________________________
Email address: _____________________________________________

☐ Yes, I would like to receive communication from this organization.

Payment information:

Credit card type (if paying by credit card):

Circle One: VISA   MASTERCARD   DISCOVER   AMERICAN EXPRESS

Credit card number: __________________________________________
Expiration date: _____________________________________________
CVV (3 digits on back of card): _________________________________

Please mail this form and your check (if not paying by credit card) to:

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