Yes! I want to help **Knox Community Hospital** grow to meet the needs of this community!

DONOR INFORMATION

Name to be listed for recognition _____

Mailing address _____

City _____ State/Zip _____

Phone _____ Email _____

MY GIFT $_____

GIVING OPTIONS

☐ **Check enclosed payable to: The Foundation for KCH**

☐ **Please contact me about planned giving.**

☐ **Please invoice me.**

☐ **Credit card gift**—*please complete section below.*

○ American Express ◉ Visa

○ MasterCard ○ Discover

Name on Card _____

Account #_____

Exp. Date _____ Security Code _____

Signature _____

Please sign/print this form then mail to the address listed below. Thank you.

The Foundation for KCH| 1330 Coshocton Road | Mount Vernon, OH 43050 | 740.393.9602