



Speare Memorial Hospital  
Development Office  
16 Hospital Road  
Plymouth, NH 03264  
(603) 238-2211  
FAX (603) 536-4828

**DONATION FORM (PLEASE PRINT)**

Name(s): \_\_\_\_\_

Address: \_\_\_\_\_

City, State, ZIP: \_\_\_\_\_

Telephone: \_\_\_\_\_ E-mail: \_\_\_\_\_

I/We would like to make a gift of:

\$50       \$100       \$250       \$500       Other: \_\_\_\_\_

Name(s) as you wish to be listed in publications: \_\_\_\_\_

Or

I/We wish to remain anonymous

<p>OPTIONAL: My gift is given      <input type="checkbox"/> In Memory Of:      or      <input type="checkbox"/> In Honor Of:</p> <p>_____</p> <p>If you would like us to notify someone about your tribute gift, please complete the following information:</p> <p>Name(s): _____</p> <p>Relationship: _____</p> <p>Address: _____</p> <p>City, State, ZIP: _____</p>
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PAYMENT OPTIONS

Enclosed is a check payable to Speare Memorial Hospital

Charge my gift for the amount indicated above to (**circle one**):      VISA      MasterCard      Discover

Credit Card #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_      Expiration Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Name as printed on card: \_\_\_\_\_

I/We will be making a gift from my/our Donor Advised Fund at:

NH Charitable Foundation     Fidelity     Schwab     Vanguard     Other: \_\_\_\_\_

Please complete this form and send to Speare Memorial Hospital at the address shown above.

**THANK YOU FOR YOUR GENEROUS SUPPORT!**