Donation Form

Please print and complete this form to make a gift to Children's Healthcare of Atlanta

Your name as you wish it to appear in printed material: _____

Company name (if corporate gift):_____

Address:_____

City:_____ State:_____ Zip:_____

Daytime phone: _____ E-mail:_____

I would like to support Children's Healthcare of Atlanta with a gift of $_____

____Check enclosed ____ AMEX ____ MasterCard ____Visa ____Discover

Credit card number: _____Exp. Date: _____

Name on credit card: _____ CVV No.: _____

Signature (required for all credit card charges):_____

I would like my gift to support:_____

If your employer will match your gift, please enclose completed form

Tribute gift (circle one): My gift is in honor or memory of: _____

Pleasenotify (name):_____

Address:_____

City: _____ State: _____ Zip:_____

Please mail this form along with your donation to:
ATTN: Children's Healthcare of Atlanta
1575 Northeast Expressway
Atlanta, GA 30329
For questions, please call 404-785-7539

_____ I would like to receive information about including Children's in my will or estate plan