Children's Miracle Network®
the alliance of premier hospitals for children

Donation Form

Date: _____

First Name: _____ **Last Name:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Email Address: _____

Phone Number: _____

Enclosed is my tax deductive gift of:

☐ **$25** ☐ **$50** ☐ **$100** ☐ **Other $**_____

___Cash ___Check ___CC _____ **/**_____

Credit Card Number **Exp. date**

benefiting the pediatric programs of

UF Health Shands Jacksonville & Wolfson Children's Hospital Baptist Health

_____

Signature of Name of Individual on Card

This gift is in the name of: _____

Please notify: _____

A special note will be sent to the individual(s) you designate.

Address of Individual mentioned above: _____

_____

Children's Miracle Network is dependent on community support to continue to provide state of the art medical care at UF & Shands Jacksonville and Wolfson Children's Hospital. Your gift will help make miracles happen in the lives of local children.

Please send donation to:

Children's Miracle Network ATTN: Nicole Ortman, Director ***820 Prudential Drive, Suite 412 Jacksonville, FL 32207***

PLEASE NOTE: A COPY OF THE OFFICIAL REGISTRATION AND FINANCIAL INFORMATION MAY BE OBTAINED FROM THE DIVISION OF CONSUMER SERVCIES BY CALLING TOLL-FREE WITHIN THE STATE (1-800-435-7352). REGISTRATION DOES NOT IMPLYENDORSEMENT, APPROVAL, OR RECOMMENDATION BY THE STATE. THE INFORMAITON IS FILES UNDER THE NAME OF BAPTIST HEALTH SYSTEM FOUNDATION, INC. SC -0362