GIVING FORM

Compassion Evangelical Hospital
PO Box 870 • Southfield, MI 48037
(313) 378-9398 • www.cehguinea.org

You can share in our commitment to give the best medical and surgical care possible according to the means that God provides, with compassion, and to share the gospel of Christ clearly with everyone who comes. When you participate, your donation will be transferred conveniently from your checking account or credit card directly to Compassion Evangelical Hospital.

Your donation will go even further because our paperwork will be reduced; our income will be more predictable, putting your donation to work immediately to help the people who are served by our mission.

Name(s) _____

Address_____

City _____ **State** _____ **Zip Code** _____

Telephone _____**Email** _____

I'd like to make a ___ Donation ___ Memorial Gift ___ Honor Gift

In Memory/Honor of: _____

As a ___ Monthly Gift ___ Quarterly Gift ___ One-Time Gift

On the ___1st of the month ___10th of the month ___20th of the month

In the amount of: ___ $25 ___ $50 ___ $100 ___$250 ___$500 $ _____ Other Amount

Please apply my gift to: ___General Operating ($4,000/mo) ___ Dr. Kristen Schmaltz ___ MIAPE ($3,300/mo)

___ Nursing School Classrooms $5,000 ___ Scholarships – specify recipient's name _____

___ Short-Term Trip – specify recipient's name _____

___ Women's Services - Community Health Program

Please transfer my donation from my:

____ Checking Account [*Please attach a voided check*]

- OR-

____ Credit Card Account ***Number*** _____ ***Expiration Date*** _____ /_____

I understand my future donations will be transferred directly from my account as stipulated above. I understand that I may increase, decrease, or suspend my gift any time through the online donation form at www.cehguinea.org or by contacting Compassion Evangelical Hospital by phone or mail. All donations provided to Compassion Evangelical Hospital originating as ACH transactions comply with U.S. Law.

Signature _____ **Date** _____
(Required)

KEEP THIS PORTION FOR YOUR RECORDS

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___ Nursing School Classrooms $5,000 ___ Scholarships – specify recipient's name _____

___ Short-Term Trip – specify recipient's name _____

___ Houston Spring Benefit - Community Health Program