Yes, I would like to be a member of Women in Philanthropy!

NAME ____

MAILING ADDRESS ____

CITY ______________________________________ STATE __________ ZIP ___________

PHONE __________________________ EMAIL ___________________________________

________ Attached is my $500 check.

________ Please bill my credit card $500. ☐ Visa ☐ MasterCard

Account # ___________________________ Exp. Date ______ CDC# (card security code) _________

Signature ____

________ I will make periodic payments.

☐ Attached is my initial gift of $________

☐ Please bill my credit card $________ monthly for ______ months ☐ Visa ☐ MasterCard

Account # ___________________________ Exp. Date ______ CDC# (card security code) _________

Signature ____

________ Please send me a reminder about my gift.

Please print and complete this form and return it to our office by mail or fax:

Baxter Regional Hospital Foundation, 624 Hospital Drive, Mountain Home, AR 72653
Phone 870-508-1770 Fax 870-508-1345