

***Yes, I'd like to help the Salem Health Foundation ...***

Mrs. & Mrs.    Mr.    Mrs.    Ms.    Miss    Dr.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

\_\_\_\_\_  
Phone

***Please accept my gift of:***    \$1,000    \$500    \$250    \$100    Other \$ \_\_\_\_\_

Check enclosed, payable to Salem Health Foundation

Charge to my:    Visa    MasterCard    American Express    Discover

\_\_\_\_\_  
Card Number

\_\_\_\_\_  
Expiration Date

\_\_\_\_\_  
CVC #

\_\_\_\_\_  
Card Holder Signature

***Please direct my gift toward:***

Cancer    CHEC    Cardiac Services    Therapy Services    Scholarships    Area of Greatest Need

Other \_\_\_\_\_

***My gift is a tribute:***    In Memory of    In Honor of

\_\_\_\_\_  
Name

\_\_\_\_\_  
Name of Person to Notify of My Gift

\_\_\_\_\_  
Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

Send me information about how I can include the Salem Health Foundation in my estate plans.

**PO Box 14001  
Salem OR 97309-5014  
503-814-1990**



**SALEM HEALTH**  
*An OHSU Partner*