Blank Children's Hospital
UnityPoint Health

Donor Information: (Please Print)

Donor Name: _____

If an Organization – Contact Name: _____

Address: Phone: _____

City: _____ State:_____Zip _____

Designation & Payment:

Donated to: ___Blank Children's Hospital_____ Designated Area: _____

Amount of Gift: $_____ Check – Cash – Charge (Circle all the apply)

Credit Card Information: Visa Master Card Discover (Please circle)
Card #: _____

Expiration date: _____CVV#_____(3 digit # on back)

Signature of gift presenter: _____Date: _____

This gift is:

In memory of: _____

In honor of: _____

To send acknowledgement to the family for this gift, please fill out the following information:

Name: _____

Address: _____

City: _____ State: _____Zip: _____

Relationship to the memorial or honoree: _____

Return to:

Blank Children's Hospital
Alissa McKinney
1200 Pleasant Street
Des Moines, IA 50309

MEMORIAL INFORMATION FORM

Blank Children's Hospital
UnityPoint Health

In Memory of:_____
Title First Middle Initial Last

Deceased Date: _____

1. ***Designate memorial money to an Iowa Health- Des Moines facility: (check one)***

   _____ Iowa Lutheran Hospital ___X__ Blank Children's Hospital

   _____ Iowa Methodist Hospital _____ John Stoddard Cancer Center

   _____ Methodist West Hospital

2. ***Designate memorial money to a project area: (check or name one)***

   _____ Area of Greatest Need Other:_____

3. Have memorial checks payable to the facility and note the memorial name on the memo line. Mail checks to:

   UnityPoint Health Foundation – Des Moines
   1415 Woodland Avenue, E-200
   Des Moines, IA 50309

   The UnityPoint Health Foundation will provide a tax receipt to the donor per IRS guidelines.

4. ***Send Memorial Acknowledgment report to:***

   The person listed will receive an initial listing of all donors, and of any new donors, twice a month. The list will include only names and addresses of donors - no dollar amounts will be included.

   Name _____
   Address_____
   City_____State_____Zip_____

   Relationship to deceased _____Phone #_____

5. ***Form completed by:*** _____Date: _____