

East Alabama Medical Center Donation Form

Donation Amount: \$ _____

Donor Information:

Title: _____ First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Tribute Information (Optional):

My gift is in (circle one) honor/memory of: _____

Please acknowledge:

Title: _____ First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Please designate my gift to:

- | | |
|--|---|
| <input type="checkbox"/> Area of greatest need | <input type="checkbox"/> Alzheimer's/Dementia Care |
| <input type="checkbox"/> Breast Health for Underserved Women | <input type="checkbox"/> The Cancer Center |
| <input type="checkbox"/> Cardiology | <input type="checkbox"/> Colorectal Screening |
| <input type="checkbox"/> The Diabetes and Nutrition Center | <input type="checkbox"/> EAMC Foundation Endowment |
| <input type="checkbox"/> HealthPlus Fitness Scholarships | <input type="checkbox"/> EAMC Mother/Baby Unit |
| <input type="checkbox"/> Parish Nurse Program | <input type="checkbox"/> Patient Crisis Fund |
| <input type="checkbox"/> Prenatal Clinic | <input type="checkbox"/> Prostate Screening for Underserved Men |
| <input type="checkbox"/> EAMC Technology Fund | <input type="checkbox"/> Unity Wellness |
| <input type="checkbox"/> Other: _____ | |

Payment Information:

Cash Enclosed: _____ Check #: _____

Credit Card Type (Circle one): Visa MasterCard American Express Discover

Cardholder's Name: _____

Credit Card Number: _____ Exp. Date: _____

*Please mail this form to: EAMC Foundation
2000 Pepperell Parkway
Opelika, AL 36801*

*Phone: 334-528-5868
Fax: 334-528-1347
Email: foundation@eamc.org*