



**Floyd Memorial Foundation
Memorials & Honorarium Giving Opportunities**

Donor Name _____

Address _____

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

E-mail _____ **Phone** _____

Donation Amount:

_____ \$50 _____ \$100 _____ \$250 _____ \$500 _____ \$750 _____ Other

Payment: _____ Cash _____ Check made payable to the Floyd Memorial Foundation

_____ **Credit Card No.:** _____ **Exp. Date** _____

Signature: _____

Donation made in (please check) _____ honor of: _____ memory of:

The Foundation will send an acknowledgment to the following:

Name(s): _____

Address: _____ **City** _____ **State** _____ **Zip** _____

Please submit this completed form to the Floyd Memorial Foundation office to the attention of
Emily Byrd via e-mail at emily.byrd@fmhhs.com, fax (812) 948-7685 or via mail to
Floyd Memorial Foundation, 1850 State Street, New Albany, IN 47150

Thank you for your contribution to the Floyd Memorial Foundation. Your donation will help support the Foundation mission to provide support to Floyd Memorial Hospital and Southern Indiana healthcare organizations to enhance the quality of care provided to our community. The Foundation will send you a tax receipt for your donation at the close of the calendar year.