

Donation Form



Please print and complete this form to make a gift to Children's Healthcare of Atlanta

Your name as you wish it to appear in printed material: _____

Company name (if corporate gift): _____

Address: _____

City: _____ State: _____ Zip: _____

Daytime phone: _____ E-mail: _____

I would like to support Children's Healthcare of Atlanta with a gift of \$ _____

Check enclosed AMEX MasterCard Visa Discover

Credit card number: _____ Exp. Date: _____

Name on credit card: _____

Signature (required for all credit card charges): _____

I would like my gift to support: _____

If your employer will match your gift, please enclose completed form

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

Please notify (name): _____

Address: _____

City: _____ State: _____ Zip: _____

Please mail this form along with your donation to:
ATTN: Children's Healthcare of Atlanta Foundation
3395 Northeast Expressway, Suite 100
Atlanta, GA 30341
For questions, please call 404-785-7539

I would like to receive information about including Children's in my will or estate plan