

# Gift Form

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DATE ▲

\$100    \$50    \$25    \$10    \$

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**ENCLOSED IS MY GIFT OF ▲** or, **OTHER AMT. ▲**

The HealthAlliance Foundation has my permission to disclose gift amount to named recipient.

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**IN MEMORY OF:** NAME ▲

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**IN HONOR OF:** NAME ▲

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OCCASION:

## FROM

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YOUR NAME ▲

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ADDRESS ▲

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CITY ▲

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STATE ▲

ZIP ▲

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TELEPHONE ▲

Please send me \_\_\_\_\_ additional copies of this Gift Form with my gift acknowledgement.

## SEND NOTIFICATION TO

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NAME ▲

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ADDRESS ▲

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CITY ▲

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STATE ▲

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ZIP ▲