Sutter Health

Foundation Name
Foundation Name Line 2 if needed

# *2018 Annual Fund*

[Name of Local Foundation]
Office of Philanthropy
P.O. Box 160045
Sacramento, CA 95816

*Make sure this address shows through the window on your enclosed green return envelope!*

☐ YES! I want to renew my support for the critical work of [local foundation] in 2018. Enclosed is my tax-tax deductible gift of:

| | | | |
|---|---|---|---|
| ☐ $XX1 | ☐ $XX3 | ☐ $XX5 | ☐ $XX7 |
| ☐ $XX2 | ☐ $XX4 | ☐ $XX6 | ☐ Other $ _____ |

☐ This gift is in memory or in honor of someone.* Information on back.

**with a gift of $250 or more, you will be recognized in our annual report next year.*

[Addressee]
[AddressLine1]
[AddressLine2]
[City], [State] [Zipcode]

Thank you! Make your check payable to [Local Hospital Foundation] and send it with this form to [local foundation address].

Or speed your generosity to work even faster at:[foundation giving page URL]

[ ] My gift is by credit card.
Please charge it to my:
[ ] VISA [ ] MasterCard [ ] AmEx

_____
NAME ON CREDIT CARD

_____
CARD #

_____
SECURITY CODE EXP. DATE

_____
SIGNATURE

_____
TELEPHONE

***Thank you,*** [Salutation]!
Your giving to [Local Hospital Foundation] shows that you are a hometown hero! You care about people fighting illness or recovering from injuries. You know the importance of top-notch healthcare for our community.

Thank you for renewing your support for the [Local Hospital Foundation] 2018 Annual Fund.

[local signature]

[local title]
[local foundation]

[local foundation address * phone number * email]

# Our Pledge to You

[Salutation], when you entrust [Local Hospital Foundation] with your kind donation, we pledge to:

- Put your gift to work here in the local community (unless you tell us otherwise).
- To use your gift with maximum efficiency for the good of our patients and the whole community.
- To be open and transparent about our finances.
- To safeguard our information.
- To respect your wishes about how we communicate with you.
- [Anything else?]

## Questions about your health? Here's help for you!

[Salutation] check the areas you'd like to know about, and we'll send you useful information right away!

- ☐ Ocular Diseases *(Cataract, Glaucoma, Presbyopia)*
- ☐ Reduced Muscular Strength and Coordination
- ☐ Cardiovascular Diseases *(IHD, Stroke and Hypertension)*
- ☐ Chronic Respiratory Illness *(COPD, Asthma, Bronchitis)*
- ☐ Mental Problems *(Dementia, Depression and Mood Disorders)*
- ☐ Complication of Diabetes
- ☐ Cancers *(Oral, Gastric, Lung and Colorectal Cancer)*
- ☐ Nutritional Deficiencies
- ☐ Dental Problems
- ☐ Hearing Defects
- ☐ Increased Susceptibility to Infections *(RTI, UTI)*
- ☐ Degenerative Neurological Diseases *(Alzheimer's disease and Parkinsonism)*

## I'm donating in honor or in memory of someone:

☐ In memory of ☐ In honor of

Name of person I'm giving in honor/memory of:

_____

_____

Name and address of person to notify of my gift (optional)

_____

_____

_____

☐ Please contact me about making a bequest through my will or trust.

☐ I have already included Sutter Health in my will or trust.

*We are grateful for the support we receive from our friends in the community. If you prefer not to receive fundraising information from us, please call us toll free at (855) 421-3221 or email us at* ***giving@sutterhealth****.org, and we will remove your name from our list. Please allow at least four weeks to process your request.*

_____

MY EMAIL ADDRESS

*With your email address, we can update you about the impact of your donation and send you event invitations.*