



GIVING FORM

Please print and complete this form to make a gift to Texas Children's Hospital.

Donor/Company Name \_\_\_\_\_
Address \_\_\_\_\_
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_
Daytime Phone \_\_\_\_\_ Email \_\_\_\_\_
Name as you wish it to appear for recognition in printed material \_\_\_\_\_

I would like to support Texas Children's Hospital with a gift of:

\_\_\_\_\_ \$25 \_\_\_\_\_ \$50 \_\_\_\_\_ \$100 \_\_\_\_\_ \$500 \$ \_\_\_\_\_

I would like my gift to support: (please check one)

- \_\_\_\_\_ Heal Sick Children Fund \_\_\_\_\_ Jan and Dan Duncan Neurological Research Institute
\_\_\_\_\_ Global Health Initiative \_\_\_\_\_ Texas Children's Pavilion for Women
\_\_\_\_\_ Surgery \_\_\_\_\_ Texas Children's Hospital West Campus
\_\_\_\_\_ Transition Medicine \_\_\_\_\_ Other Service or Department: \_\_\_\_\_

\_\_\_\_\_ Check enclosed \_\_\_\_\_ AMEX \_\_\_\_\_ Discover \_\_\_\_\_ MasterCard \_\_\_\_\_ Visa

Card number \_\_\_\_\_ Exp. \_\_\_\_/\_\_\_\_

Signature \_\_\_\_\_
(required for all credit card charges)

\*\*\* If your employer will match your gift, please enclose completed form. \*\*\*

Optional - I would like my gift to be in honor or in memory of a special person:

My gift is \_\_\_\_\_ in honor \_\_\_\_\_ in memory of \_\_\_\_\_
(please print name)

Please notify: Name \_\_\_\_\_
Address \_\_\_\_\_
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

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Thank you for your generous support of Texas Children's Hospital.

Has anyone in your family received care at Texas Children's Hospital?

\_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Child \_\_\_\_\_ Grandchild \_\_\_\_\_ Other \_\_\_\_\_

\_\_\_\_\_ I have included Texas Children's in my will or estate plan.

\_\_\_\_\_ Please send me information about including Texas Children's in my will or estate plan.

Please mail your completed form along with your gift to:

Texas Children's Hospital • Office of Development • 1919 S. Braeswood Blvd., Ste. 5214 •
Houston, TX 77030-4412 (For questions, call 832-824-6806.)