

# I MY HOSPITAL



Thank you for making a donation to Calhoun Liberty Hospital, serving the residents of Calhoun and Liberty counties, as well as the surrounding areas. This hospital is the heartbeat of our community, and we appreciate your support.

## Payment information:

- Check enclosed \$ \_\_\_\_\_  
*(Payable to Calhoun Liberty Hospital Association)*
- Charge to my credit card \$ \_\_\_\_\_  
 VISA  MasterCard  
 American Express  Discover

Name on credit card: \_\_\_\_\_  
Card Number: \_\_\_\_\_ Exp. Date: \_\_\_\_\_ Security Code: \_\_\_\_\_

- My employer offers a matching gift program. *(Please include your completed employer's matching gift form)*
- How would you like your name to be published? \_\_\_\_\_
- I would like my donation to remain anonymous

## Personal Information / Authorization: *(Required for credit card transactions)*

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Submit to: *(Please print out and sign form before submitting)*

**Via Mail:** Calhoun Liberty Hospital, 20370 NE Burns Ave., Blountstown, FL 32424  
Attn: Donations

**Via Email:** [nathanebersole@calhounlibertyhospital.com](mailto:nathanebersole@calhounlibertyhospital.com)

**Via Fax:** (850) 674-1649

**We respect your privacy!** Please know that personal information will not be shared with any other organizations.

Contributions may be tax deductible to the fullest extent of the law.

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**THANK YOU FOR YOUR SUPPORT!**