



St Peter's Hospital Foundation

ST PETER'S HEALTH PARTNERS

A Member of Trinity Health

DONATION FORM

to benefit St. Peter's ALS Regional Center

Name(s): _____

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Enclosed is my gift \$ _____. Please make checks payable to St. Peter's Hospital Foundation

Please charge my credit card: AMEX VISA MC DISCOVER

Amount to be charged: \$ _____

Name as it appears on card: _____

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Special Instructions (Please Print):

This gift is in Memory of: in Honor of: _____

Please send acknowledgement to:

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I/we prefer this gift to remain anonymous.

Return completed form with payment to:

St. Peter's Hospital Foundation
310 S. Manning Blvd, Albany NY 12208
518-482-4433 givetostpeters.org

~ Thank you for your thoughtful contribution ~