MARSHFIELD CLINIC HEALTH SYSTEM YMCA
CHANGING LIVES. BUILDING FUTURES. CAPITAL CAMPAIGN
PLEDGE FORM

Donor Name

_____

_____

Company Name

_____

_____

Address

_____

_____

City _____

State _____ Zip _____

Phone (Wk) _____-_____-_____ (Hm) _____-_____-_____ Email

_____

PLEDGE INFORMATION

ONE-TIME GIFT

❑ I prefer to make a one-time donation to the Marshfield Clinic Health System YMCA in the amount of
$_____.

❑ Enclosed is my check. Make check or money order payable to Marshfield Area YMCA.

OR

❑ Charge my credit card account: ❑ Visa ❑ MasterCard ❑ Discover

Credit Card Number

_____

Exp. Date _____ 3-Digit Security Code_____

THREE-YEAR PLEDGE (option for pledges of $1,000+)

❑ My total pledge is $_____.

I wish to spread my donation over ❑ 1 ❑ 2 ❑ 3 year(s), beginning in _____, 2017

Please send invoice ❑ Annually ❑ Quarterly ❑ Monthly beginning in _____, 2017

ACKNOWLEDGEMENT

Please print your name as you would like it to appear in formal recognitions and/or publications:

_____

_____

❑ I would like my gift to be anonymous and do not want my name listed for recognition.

_____

_____ _____

Donor Signature Date

Please complete and return to:
Marshfield Clinic Health System YMCA
ATTN: Development Office
410 West McMillan Street, Marshfield, WI 54449

NOTE: Donations are tax deductible to the extent allowed by the law. Deductibility of your contribution should be referred to your tax advisor.