Somerset
MEDICAL CENTER FOUNDATION

Your gift, no matter the amount, will have a powerful impact on the lives of those in your community.

Name _____

Address _____

City _____ **State** _____ **Zip** _____

Telephone ( ) _____

E-mail _____

If you or your spouse are employed by a company with a **Matching Gift Program** that supports local hospitals, please contact your Human Resources Department to request a Matching Gift Application and mail it to the address below with your contribution. Your gift may be doubled, or sometimes tripled, by the company's matching gift program.

- ❑ Enclosed is my gift of $_____.
- ❑ I would like to make a monthly gift of $_____ to be charged to the credit card listed below.

I would like my gift to be directed to:

- ❑ Annual Fund ❑ The Steeplechase Cancer Center ❑ Other _____

My gift is:

- ❑ In Honor Of: _____
- ❑ In Memory Of: _____

Please send an acknowledge of this gift to:
Name: _____
Address: _____
City: _____ State: _____ Zip: _____

If remitting a check please make your check payable to Somerset Medical Center Foundation.

I prefer to charge my:

- ❑ VISA
- ❑ MASTERCARD
- ❑ AMERICAN EXPRESS
- ❑ DISCOVER

Account Number: _____

Signature: _____

Expiration Date:_____

To make your gift please mail this form to:

Somerset Medical Center Foundation
110 Rehill Avenue
Somerville, NJ 08876

For more information, or to process your request by phone, contact the Foundation Office at (908) 685-2885. Our staff is available between 8:30 a.m. and 5 p.m. Monday through Friday.

Thank you for your generosity and support!