Print Form Reset Form

INOVA™
Join the future of health.

DONOR REPLY FORM

Appeal Code: 15ONLINEWEB

Inova Health Foundation

DONOR INFORMATION

Preferred Title:

First Name: _____ MI: ___ Last Name: _____ Suffix: _____

Street Address: _____

_____

City: _____ State: _____ Zip Code: _____

E-mail Address: _____

Home Phone: _____ Work Phone: _____ Ext: _____

ONE-TIME GIVING METHOD

☐ YES, I will support the Inova Health Foundation with a one-time contribution of: _____

RECURRING MONTHLY GIVING METHOD

☐ YES, I will support the Inova Health Foundation with a recurring monthly contribution of:

○ $10 ○ $15 ○ $25 ○ Other _____

○ My company will match my gift. Visit http://www1.matchinggifts.com/inova/ and search for your company and complete the online application. **COMPLETE AND PRINT DONOR FORM THEN CLICK ON WEB LINK - DONOR FORM WILL RESET WHEN YOU CLICK ON LINK.**

My company is: _____ ☐ Current Employee ☐ Retired Employee

DESIGNATE YOUR GIFT TO AN INOVA HOSPITAL

- ○ Inova Fairfax Hospital
- ○ Inova Children's Hospital
- ○ Inova Women's Hospital
- ○ Inova Heart and Vascular Institute
- ○ Inova Mount Vernon Hospital
- ○ Inova Fair Oaks Hospital
- ○ Inova Loudoun Hospital
- ○ Inova Alexandria Hospital

DESIGNATE YOUR GIFT TO AN INOVA PROGRAM

- ○ Life with Cancer
- ○ Inova Juniper Program
- ○ Inova Nursing Education Programs
- ○ Inova Blood Donor Services
- ○ Inova Kellar Center
- ○ Inova VNA Home Health
- ○ Inova Community Health Programs
- ○ Inova Comprehensive Cancer and Research Institute

○ Please use my gift to benefit the greatest need at Inova.

○ Please specify any other Inova initiative that you would like to support.

Other: _____

Donor Name: _____

PAYMENT INFORMATION

Check Number: _____ Please make check payable to: ***Inova Health Foundation***

Please charge my credit card: ○ MasterCard ○ VISA ○ American Express

Cardholder Name: _____

Cardholder Telephone Number: _____

Account Number: _____

Expiration Date: _____ (MM-YYYY) **Last 4 Digits of Account Number:** ____

Cardholder Signature: _____ **Card Security Code:** ____

TRIBUTE GIFTS

○ I would like to dedicate my gift in honor of: _____

○ I would like to dedicate my gift in memory of: _____

Please send notification of my gift to:

Name: _____

Address: _____

_____

City: _____ State: _____ Zip Code: _____

How would you like to be referred to in the notification letter?:

_____

PLANNED GIVING PROGRAM

☐ YES! Please send me information on how I can include Inova Health Foundation in my will or trust.

☐ I have already made plans to include Inova Health Foundation in my will or trust.

Print then Mail completed form along with your contribution to:

Inova Health foundation
ATTN: Gift Administration
8110 Gatehouse Road, Suite 200 East
Falls Church, VA 22042
Tel: 703-289-2072 Fax: 703-289-2073 E-mail: foundation@inova.org

The Inova Health Foundation is a public charity under 501(c)(3) of the Internal Revenue Code. Contributions are deductible to the extent permitted by law.

***** Inova Health Foundation does not rent, sell or exchange donor information.***

Print Form

Donor Name: _____