Memorial Gift Form

Children's Hospital
New Orleans
LCMC Health

Name of deceased_____

Acknowledge to _____

Address_____

City/State/Zip_____

Relationship to deceased_____

Donor name_____

Address_____

City/State/Zip_____

Phone ( ) _____ -_____

Email_____

Acknowledge as a gift from_____

Payment

O Enclosed, please find my check for $_____ (amount of gift) made payable to Children's Hospital.

O Please charge $ _____ (amount of gift) to my

O Visa O MasterCard O American Express O Discover

Card number:_____

Expiration date: _____CVV (Security Code):_____

Name as it appears on card:_____

Signature:_____Date:_____

Return Form

By mail: Children's Hospital New Orleans
Office of Development
200 Henry Clay Ave.
New Orleans, LA 70118

By Fax: 504.896.3964

Thank you for helping us, help kids!