PROCTOR
Health Care Foundation

Partners In Excellence

I will become a Partner In Excellence with a tax-deductible contribution to the Proctor Health Care Foundation in the amount of:

□ $1,000 □ $2,500 □ $5,000 □ $7,500 □ Other $ _____

Payment Enclosed: □ Check □ MasterCard □ Visa □ Discover

Credit card number _____

Expiration _____ 3-digit security code _____

□ Please use this gift where the need is greatest.

□ Please contact me to discuss how I would like my gift to be used.

□ Please send me information on how I can include the Proctor Health Care Foundation in my estate plans.

Name(s) _____

Company _____

Address _____

_____

Phone (HOME) _____

(BUSINESS) _____

E-mail _____

□ I wish to remain anonymous.

□ I wish my names(s) to be listed along with other donors as follows:

_____

This gesture of support is being made:

□ In Honor of: □ In Memory of:

_____

Signature(s):_____ Date:_____

Please make checks payable to:
Proctor Health Care Foundation
5409 North Knoxville Avenue * Peoria, Illinois 61614
The Foundation is a non-profit 501(c)(3) organization.
Gifts are tax deductible as prescribed by law.
THANK YOU!