THE University of Vermont HEALTH NETWORK

Alice Hyde Medical Center

☑ **YES!** I want to support my community hospital.

Donor Information:

Name: _____

Address Lines: _____

City: _____ State: _____ Postal Code: _____

Email: _____ Phone: _____

Please use my gift to support:

☐ Area of Greatest Need - Unrestricted
☐ The Reddy Cancer Treatment Center
☐ The Kalpana Reddy Cancer Patient Care Fund
☐ The Breast Cancer Patient Care Fund
☐ The Alice Center
☐ Activities at The Alice Center
☐ Alice Hyde Workforce Development

I wish my gift to be:

☐ In Honor of: _____

☐ In Memory of: _____

☐ I would like my gift to be anonymous.

One-time Gift: $_____

Monthly Gift: $_____ I'd like to provide dependable ongoing support.
Please charge my credit card every month.

☐ Check enclosed made payable to ***Alice Hyde Medical Center***

Credit cards accepted:

☐Amex ☐ Master Card ☐ Visa ☐ Discover

_____ _____

CARD NUMBER EXP DATE

_____ _____

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SIGNATURE

For further information, to give a gift by phone or make a gift of stock, call (518) 481-2794.

ALICE HYDE PHILANTHROPY
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