the Campaign for

JOHN R. OISHEI
Children's Hospital
A Kaleida Health Facility

COMPLETE A ROOM
with Care

DONOR INFORMATION

Full Name: *Last*______________________________ *First*________________________ *M.I.* ______

Company ____

Street Address ____ *Apartment/Unit #*_________

City _________________________________ *State*_________________ *ZIP Code* __________

Phone ___________________________ *Email*____

GIFT PLEDGE INFORMATION

I (we) pledge a total of _______________ *payable in increments of $*_________ *per year for* ________ *years*

Payment frequency __________ *to begin day* ________ *month* _______ *year* _________

Other ____

We will Complete a Room with Care:

$50,000 Level
($10,000 a year for 5 years)

- ☐ Neonatal Intensive Care Unit
- ☐ Pediatric Intensive Care Unit
- ☐ Hematology/Oncology

$25,000 Level
($5,000 a year for 5 years)

- ☐ Mother Baby Unit
- ☐ Medical Surgical Room
- ☐ Long Term Monitoring

$10,000 Level
($2,000 a year for 5 years)

- ☐ Multi Specialty Clinic Room
- ☐ Pre/Post Op Recovery Room
- ☐ Procedure Room

We will make a gift of $ _________

Gift Recognition: *Name(s)* ____

____

Signed _________________________________ Date _________

FAX form to: 716-882-4054 or mail to: The Women & Children's Hospital of Buffalo Foundation
1028 Main Street Fl 4 • Buffalo, NY 14202 Questions? 716-881-8230 • visit us: foundation.wchob.org/childrens