

# GIVING FORM

Ms.  Mrs.  Mr.  Mr. and Mrs.  Dr.

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone Day: \_\_\_\_\_ Business: \_\_\_\_\_

E-mail: \_\_\_\_\_

***I would like to make a gift of:***

\$1,000  \$500  \$250  \$100  Other \_\_\_\_\_

Please charge my:  MasterCard  Visa  Discover  American Express

Card Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

***My Gift is for:***  The Children's Hospital of Buffalo Foundation

I would like my gift restricted to the following area at the John R. Oishei Children's Hospital:

\_\_\_\_\_

***Please list this gift from:*** \_\_\_\_\_  This gift is anonymous. Please do not list my name in publications.

This gift is  in memory of:  in honor of:

Name \_\_\_\_\_ Please Notify \_\_\_\_\_

Occasion \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone \_\_\_\_\_

I have remembered Oishei Children's Hospital or program in my will or estate.

I would like to know how to remember Oishei Children's Hospital or program in my will or estate plans.

I would like to learn about a gift that pays income to me.

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***Make checks payable to the  
CHOB Foundation and mail to:***

The Children's Hospital of Buffalo Foundation  
1028 Main Street, Floor 4  
Buffalo, NY 14202

**Questions?** Please call the Foundation  
office at (716) 881-8230.  
fax: 716-882-4054  
[www.chobfoundation.org](http://www.chobfoundation.org)



The Children's Hospital  
of Buffalo Foundation

*Thank you for your gift!*