Mt Rose
HEALTH CENTER
PALLIATIVE CARE AND HOSPICE

THANK YOU FOR YOUR GIFT!

DONOR INFORMATION

Name: _____

Street Address: _____ State: _____

City: _____ Zip code _____

Phone: _____ Email: _____

PAYMENT INFORMATION

Please make check payable to: **Mt Rose Health Center Palliative Care and Hospice**

Amount: $ _____ Card Number _____

Billing Zip Code: _____ Expiration Date: (mm/yy) _____ Security Code: _____

☐ Make my gift recurring: ◇ monthly ◇ quarterly ◇ annually

GIFT DEDICATION

◇ In Honor of: ◇ In Memory of: Name: _____

◇ Please send notification of my gift Name: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

◇ Include Donation Amount. ◇ Do NOT include donation amount.

409 Benedicta Avenue Suite A, Trinidad CO 81082
Phone: 719-846-8478 Fax: 719-846-2941 Donate: www.mtrosehealthandhospice.com
Mt Rose is a 501©(3) organization EIN# 81-2196206