Yes, I'd like to donate to Lamprey Health Care.

If you chose un-designated, we will determine where your donation can have the greatest impact.

SELECT DONATION TYPE:

☐ One Time Donation Recurring
☐ Donation (choose one)
__ Monthly
__ Annually

DONATION PREFERENCE:

☐ Un-designated / General
☐ Capital Development Fund
☐ Ann's Fund (provides direct assistance to our patients)

SELECT DONATION AMOUNT:

☐ $100.00 ☐ $500.00
☐ $250.00 ☐ $1,000.00
☐ OTHER $_____

YOUR CONTACT INFORMATION:

Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Mr. & Mrs. ☐ Dr. ☐ Other: _____

Name (first, middle, last): _____

Street: _____

City/State/Zip: _____

Telephone: _____

Email: _____

☐ *Yes, I would like to receive communications from Lamprey Health Care.*

PAYMENT INFORMATION:

☐ Check Enclosed
(payable to Lamprey Health Care)

☐ VISA ☐ MasterCard ☐ American Express ☐ Discover Network

Credit Card #: _____

Exp. Date: _____ CSC (Card Security Code):_____
3 or 4 digit # printed on your card

☐ Use same name & address as listed above.

Card Holder's Name: _____

Card Holder's Address: _____

Card Holder's City/State/Zip: _____

MAIL YOUR GIFT TO:

Lamprey Health Care
207 South Main Street
Newmarket, NH 03857

(603) 659-3106
www.lampreyhealth.org

LAMPREY HEALTH CARE
Where Excellence and Caring go Hand in Hand