

Donation Form



Children's Health Fund

Date: _____

How did you hear about CHF? _____

**Indicates information required to process your contribution.*

*Name: _____

*Address: _____

*City: _____ *State: _____ *Zip Code: _____

*Telephone: (H) _____ (W) _____

Email Address: _____

*Gift Amount: _____

In honor of: _____ In memory of: _____

Send notification to: _____

Name: _____

Address: _____

Message: _____

Payment method: (please circle one)

Check Enclosed** VISA*** MasterCard AMEX

***Please make checks payable to The Children's Health Fund.*

Credit Card Number: _____

Expiration Date: _____

Name (as it appears on card): _____

***Billing Zip Code (necessary to process VISA cards): _____

I would like to be included on invitation lists for upcoming events.

I have submitted this contribution to my employer for a matching gift.

Mail completed form to: Development Department
The Children's Health Fund
215 W. 125th Street, Suite 301
New York, NY 10027