Cooperstown Medical Center Foundation Contribution Form

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____

Email _____

In Support of the Cooperstown Medical Center, I/We are pleased to make the following contribution:

Enclosed is my gift of:

- $50 ☐
- $100 ☐
- $500 ☐
- Other ☐ _____

Make checks payable to the CMC Foundation

_____Please contact me/us to make a gift through a will or trust, insurance or retirement assets, or gifts.

_____I/We wish this gift to be given anonymously.

_____I/We would like to transfer securities. Please call me.

_____ Please contact me about contribution through Automatic Withdrawal from my bank account

Please use my gift for:

- _____Where Needed Most
- _____Nursing Home
- _____Hospital
- _____Clinic
- _____Other

Cooperstown Medical Center Foundation

1200 Roberts Ave
Cooperstown, ND 58425

Phone: 701-797-2221 ext 7108
Fax: 701-797-2421
E-mail: foundation@coopermc.com

Always here. Always near.

Tribute Gift:
I/We _____ **wish to provide this gift:**

In Memory or Honor of _____

On the Occasion of _____

Please send notice of our tribute gift to:

Name: _____

Address: _____