

Yes, I want to help support the Grace Leland Tribute Fund

Enclosed is my gift

\$1,000 \$500 \$250 Other \$ _____

Check enclosed payable to: **Northridge Hospital Foundation**

Bill my credit card:

Card # _____

Exp Date _____ CSV _____

Name _____

Address _____

City, St., Zip _____

Email _____

Phone _____

I wish to remain anonymous

If you would like your gift to honor an individual, please see reverse side.

THANK YOU!



*Scan to
donate online*



**Northridge Hospital
Foundation.**

A Dignity Health Member

Thank you for your support

I would like to make my gift: in honor of in memory of

Name(s)

Please send notice of my gift to:

Name(s)

Street Address

City, State, Zip

My company will match my donation (form is enclosed).

Leave a Legacy Gift:

- Please tell me how I can make a gift to Northridge Hospital Foundation through my will, a bequest or a planned gift.
- I have already included Northridge Hospital Foundation in my will or living trust, and I would like to notify the Foundation to make sure my wishes are fully understood.

Visit us at: www.supportnorthridge.org