

DANIELS MEMORIAL HEALTHCARE FOUNDATION DONATION FORM

Please complete all sections of this form.

Your donation will help fund DMH Foundation's goal for added medical equipment, technology, and education.

All donations benefit the local Daniel Memorial Healthcare Center through the Foundation.

CONTACT INFORMATION

Full Name _____ Company (if any) _____

Address _____

Address (cont) _____

City _____ State _____ Zip Code _____

DONATION AMOUNT

☐ \$25

☐ \$50

☐ \$100

☐ \$250

☐ \$500

Other Amount

PAYMENT and DONATION INFORMATION

_____ Check enclosed (payable to the *Daniels Memorial Healthcare Foundation*).

_____ Cash enclosed.

_____ I wish to donate confidentially and without acknowledgment.

_____ I would like to donate to the Greatest Medical need.

_____ I would like my donation to be in Memory or in Honor of _____

_____ I would like my donation to be restricted and used only for _____

Acknowledgement for Memory or in Honor to be sent to:

Name _____ Address _____



Send by mail or email attachment to:
Daniels Memorial Healthcare Foundation
P O Box 81, Scobey, MT 59263
dmhf@nemont.net