

2017 PHYSICIAN GIVING CAMPAIGN

Every Gift Counts.



PARTNERSHIP IS
POWERFUL MEDICINE.

Southwestern
Vermont

HEALTH CARE
FOUNDATION



2017 SVHC Physician Giving Campaign

Yes, I want to support Southwestern Vermont Health Care with a gift to the 2017 Physician Giving Campaign.

Donors who make annual gifts of \$1,000 or more are considered **Equinox Circle Members** and are honored at the following levels in the **SVHC Annual Report**. Gifts are recognized from Oct. 1–Sept. 30 each year.



Benefactor	\$100,000 +	Leader	\$5,000–\$9,999
Philanthropist	\$50,000–\$99,999	Innovator	\$2,500–\$4,999
Guardian	\$25,000–\$49,999	Pacesetter	\$1,000–\$2,499
Patron	\$10,000–\$24,999		

Name (please print): _____

I wish for my gift to be anonymous.

Gift/Pledge Amount: \$ 5,000 \$ 1,000 \$ 500 \$ 250 \$ 125 Other \$ _____

I wish to join the Equinox Circle, SVHC's leadership giving society, and enjoy its membership benefits, with my gift of \$1,000 or more.

Please use my gift to support:

Where needed most

Southwestern Vermont Regional Cancer Center

SVMC Northshire Campus

Investments in new technology

Centers for Living and Rehabilitation

SVMC Pownal Campus

Southwestern Vermont Medical Center

SVMC Deerfield Valley Campus

Other: _____

Payment:

Enclosed is a check payable to SVHC Foundation in the amount of \$ _____.

My gift is in memory / recognition of: _____

Credit Card Options:

I authorize a **one-time credit/debit card charge** in the amount of \$ _____.

I authorize a **monthly credit/debit card charge** in the amount of \$ _____ per month through Sept. 30, 2017.

I authorize a **monthly credit/debit card charge** in the amount of \$ _____ per month until further notice.

Credit/Debit Card Information: VISA MasterCard American Express Discover

Account #: _____ Expiration Date: _____ CSC: _____

Cardholder's signature: _____ Cardholder's name as it appears on card: _____

Address associated with this card: _____

Payroll Deduction Options:

I am employed by: Dartmouth-Hitchcock Southwestern Vermont Medical Center Other (unfortunately, payroll deduct is not available to you)

I pledge a **total sum of \$** _____ and authorize my employer to take a **one-time payroll deduction** for the full amount.

I pledge a **total sum of \$** _____ and authorize my employer to **deduct payments** on my pledge. The amount deducted each pay period will be determined by the number of pay periods remaining in the fiscal year, which runs from Oct. 1, 2016 through Sept. 30, 2017.

I authorize my employer to **deduct the sum of \$** _____ **per pay period** until Sept. 30, 2017.

I authorize my employer to **deduct the sum of \$** _____ **per pay period** until further notice.

Thank you for your support! All gifts are tax deductible to the fullest extent of the law.

Please return your completed form in the enclosed reply envelope or deliver to: SVHC Foundation, 100 Hospital Drive, Bennington, VT 05201

For questions, please contact us at 802-447-5017 or foundation@svhealthcare.org.