



PLEASE FILL OUT THE FOLLOWING INFORMATION:

Title: _____

First Name: _____ Last Name: _____

Company: _____

Address: _____

Address 2: _____

City: _____

State: _____ Zip: _____

Phone Number: _____

Alternate Phone Number: _____

Fax Number: _____ E-mail address: _____

PLEASE PROVIDE INFORMATION FOR ALL THAT APPLY:

Please contact me at this number regarding a gift other than cash: (_____)

I would like to make my contribution in memory or in honor of: _____

Address to send an acknowledgement of your gift:

Name: _____

Address 1: _____

Address 2: _____

City, State, Zip: _____

Name to be signed on acknowledgement: _____

FORM OF PAYMENT (PLEASE CHECK EITHER ONE):

- Check (please make checks payable to Lake Taylor Transitional Care Hospital Foundation)
- Credit Card (We accept all major credit cards with the exception of American Express)

Credit Card Number: _____

Name as it appears on Card: _____ Expiration Date: _____

The LTTCH Foundation is a 501 (c) (3) Organization.

PLEASE MAIL THIS FORM BACK TO THE FOLLOWING ADDRESS:

Lake Taylor Transitional Care Hospital Attn:
Lake Taylor Foundation
1309 Kempsville Road
Norfolk, VA 23502
sherri.stein@laketaylorfoundation.org

**SHOULD YOU HAVE ANY
QUESTIONS, PLEASE CALL
757-572-9190**