Augusta Health Foundation

*Women's Giving Circle est. 2017*

# New Member Pledge Form

Yes! I want to be a member of the Augusta Health Foundation Women's Giving Circle.

Name:_____

Street:_____

City:_____ State:_____ Zip:_____Phone:_____

E-mail:_____Cell:_____

Date: _____

My commitment of $1,000 per year over three years, for a total of $3,000 will be paid in the form of:

☐ Cash/Check ☐ Credit Card

(Please make checks payable to: Augusta Health Foundation)

I would like to make my gift in installments: ☐Monthly ☐Quarterly ☐ Annually

(If paying via credit card, your pledge balance will be billed to your credit card as you select. If paying by check, the Foundation will send you reminder statements on the basis you select.)

Credit Card Number:_____

Exp. Date:_____ CID#:_____Signature:_____

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540-332-5174