I would like to contribute: □ $1,000 □ $500 □ $250 □ $100 □ $50 □ Other gift: $ _________

In honor of (caregiver's name) __________________________ Department: _____________________

Your Name: ____ Phone: __________________________

Address: ____ e-mail: _________________________

City: ____________________________ State: __________ ZIP: ____________

□ I wish to remain anonymous.

Comments to caregiver (optional):

Please direct my gift to: □Area of Greatest Need
□Ben & Adith Miller Patient Care Fund
□Other: _______________________

Payment method:

1. **Check** enclosed made payable to the **Winona Health Foundation**.
2. Please charge my □VISA □MasterCard □Discover □American Express

_________________________________	___________	_________________________________
Card number	Exp. Date	Cardholder Signature

3. **Give online at:** www.winonahealth.org/wh_foundation/

Please return your completed request to the Winona Health Foundation Office.
855 Mankato Avenue
Winona MN 55987