



Remit to: ACMH Foundation
 One Nolte Drive
 Kittanning, PA 16201
 724-543-8850
www.acmh.org

Tax Deductible Contribution

Name/Organization _____
 Address _____
 Phone _____ Email _____ Website _____
 Check here if you would like your website name and link placed on our website. _____

Print on the line above as you wish to be mentioned on the "Friends of the Foundation" page of the ACMH Foundation website. If appropriate, include name of honored or memorialized individual.

If using a credit card, please complete the following:

Name of Credit Card _____ Name as written on Credit Card _____
 Acct Number _____ Expiration Date _____ Security Code _____

General Fund

To be used for Programs support
 \$ _____

Tree of Life Endowment

\$ _____
 \$500 Leaf \$1000 Stone \$2500 Stone

Restricted Funds

Please select Fund and Amount to be applied from the total Donation.

\$ _____ Total

_____ Cancer Center Assistance	\$ _____	Amount to apply
_____ Cancer Center Garden of Hope	\$ _____	Amount to apply
_____ Cancer Center Outreach	\$ _____	Amount to apply
_____ Cancer Center Education	\$ _____	Amount to apply
_____ Wellness Initiatives	\$ _____	Amount to apply
_____ Hospitalized Patient/Family Program	\$ _____	Amount to apply
_____ Psychiatry Fund	\$ _____	Amount to apply
_____ Medical Staff Fund	\$ _____	Amount to apply
_____ Other _____	\$ _____	Amount to apply

The Foundation members sincerely thank you for your generous donation. With your assistance, the hospital and community health will benefit by developing and continuing much-needed programs.