DONATION FORM

WAIKIKI HEALTH

MEDICAL & DENTAL • BEHAVIORAL HEALTH • SOCIAL SERVICES

I wish to support Waikiki Health with a gift in the amount of $ _____

Please designate my contribution for the following area(s):

- ☐ The area of greatest need
- ☐ Primary Care Services
- ☐ Youth Outreach (YO!) Program
- ☐ Keauhou Shelter
- ☐ PATH Clinic
- ☐ Other: _____

Donor Information

- ☐ I wish to remain anonymous

Name: _____

Business/Organization Name (if applicable): _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone Number(s): Home _____ Work _____

Email: _____

How Did You Hear About Us?

- ☐ Patient / Client of Waikiki Health
- ☐ Friend / Family Member
- ☐ Received Postal Mail
- ☐ Received Email
- ☐ Television / Radio Commercial
- ☐ Other:

Payment Method

- ☐ Cash / Check enclosed (payable to: Waikiki Health)
- ☐ Please charge my credit card: ☐ Visa ☐ MasterCard ☐ American Express

Card Number: _____ Expiration Date: _____

Cardholder Name: _____ Signature: _____

Tribute (optional)

This donation is *in memory of*: _____

This donation is *in honor of*: _____

Please send an acknowledgement of this tribute to (optional): *(Donation amount is not mentioned.)*

Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

This form and your gift can be mailed to:

Waikiki Health, Attn: Development Office • 935 Makahiki Way, Honolulu, HI 96826