LOMA LINDA UNIVERSITY
HEALTH

Bring A Smile Program Donation Report

(Please use a Donation Envelope for gifts of Cash or Checks.)

From Mr./Mrs./Ms._____ Date_____
(Contact Name if Company or Organization)

Company or Organization_____

Address_____ Phone _____

City_____ State_____ Zip _____

In memory/honor of _____
(circle one)

If you wish to receive acknowledgement of your donation, please provide a full name and address where we may send the acknowledgement.

_____

_____

A letter will be sent acknowledging your gift described below. Receipts will be sent for cash/checks.

Description of gift (number & type of items, whether new or used)	**Donor's estimation of value**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

For office use only:
Staff/Volunteer accepting gift _____

(Please provide full name and extension where you may be reached if needed.)

Please send to Children's Hospital Foundation, Room 1816; Phone 558-8008

_____Hours Recorded _____Excel List _____Advancement _____Thank You