A Gift in Remembrance

A Gift of Hope

Albany Medical Center

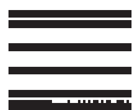
Your stamp on this envelope is an additional contribution to our work.

BUSINESS REPLY MAIL

FIRST CLASS MAIL PERMIT NO. 3271 ALBANY NY

POSTAGE WILL BE PAID BY ADDRESSEE

ALBANY MEDICAL CENTER FOUNDATION
P.O. BOX 8928
ALBANY NY 12214-8081



NO POSTAGE NECESSARY IF MAILED IN THE UNITED STATES

Albany Medical Center

More and more, the friends, family members and associates of bereaved persons are choosing to express their respect in a more enduring way than with cards and flowers. Making a charitable contribution in the name of a lost loved one can have special meaning to both the family and the donor. This lasting gift will also serve to support Albany Medical Center in its mission to achieve excellence in patient care, education and research – making a tangible difference in the health of our community.

Albany Medical Center

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Albany, New York 12208-3478

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When You'd Like to Express More than Sympathy

Using the attached form, you may restrict your gift to a certain department or division, or you may prefer your gift to support one of our three missions. You may also choose to leave your gift unrestricted, thereby allowing Albany Medical Center to use the funds where they are most needed. Regardless of where you place your gift, be assured that it will make an immediate difference in the important work we do. In addition, it is our commitment that every dollar of your contribution will be used specifically by the department or program you choose to support.

A card announcing your gift will be mailed to the family of the deceased – no mention will be made of the gift's value. For tax purposes, you will receive an acknowledgement for your gift as well. Your gift will be recognized in Albany Medical Center's Annual Report of Gifts.

Tear here.

Name ____

Address ____

City ____

State ________________ Zip _________________________

Home Phone ______________________________________

Email ____

Please make my gift:

In memory of: _____________________________________

Please send notification of my gift to:

Name ____

Address ____

City ____

State ________________ Zip _________________________

I would like my contribution to benefit Albany Medical Center in the area of:

- ❑ Unrestricted
- ❑ Patient Care
- ❑ Research
- ❑ Education
- ❑ Other (list department or program)

Enclosed is a gift of:

- ❑ $25
- ❑ $50
- ❑ $100
- ❑ $250
- ❑ $500
- ❑ Other _______

❑ **Enclosed is a check payable to:** *Albany Medical Center Foundation*.

❑ **Please charge my credit card in the amount of:**

$ ___________ ❑ Visa ❑ MC ❑ AMEX

Exp. Date _________

Card number_______________________________________

Authorized Signature_____________________________

GPB

Please complete this form, detach from brochure, fold and insert in envelope.