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Contacted By:	Date:
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The Outer Banks Hospital Development Council
4800 S. Croatan Highway
Nags Head, North Carolina 27959
(252) 449-5933
Tax ID # 20-0777374

DONOR INFORMATION			TAXIL	<i>σ</i> # 20-011101.
Name:	Company:			
Please acknowledge my donation in printed mate	erials as:			
This donation should be listed as ANONYM acknowledge the gift and provide a letter for tax purposes. A	•	•		
Mailing Address:	City:		State:	Zip:
Telephone:	Email:			
GIFT OPTIONS				
I pledge a gift in the amount of \$				
Check: Please make your check payable to The above.	Outer Banks Hospital Developm	ent Council and retur	n it to the addr	ess listed
Credit Card: Please charge my gift to my: (circle	e one) MC VISA AMEX	DISCOVER		
Account Number:	Exp. Date:			
Signature:	CVV Number:			
Optional:				
☐ My employer will match this gift. En	closed is my matching gift form.			
My gift is: In Memory of:	In Honor of:			
Send Acknowledgement to:				
In-KIND DONATIONS				
☐ Item (description)	/\$	(value)		
Service (description)	/\$	(value)		
Silent Auction Donation Notes:				
DONATION PURPOSE				
OBX Cancer Cares Fund (Get Pinked! & Mo	re; Cancer screenings and support	services for cancer pa	atients.)	
☐ 2020 Gala (Proceeds will benefit the Cancer	Center Campaign Fund and the H	ealth Coach Fund.)		
☐ Cancer Center Capital Campaign (Build an C	Outer Banks Hospital Cancer Cente	er.)		
☐ Health Coach Fund (Wellness screenings, he	ealth education and health coachin	g.)		
Outer Banks Hospital Greatest Need (For ne	eds of the Outer Banks Hospital as	s they arise.)		
☐ Get Pinked! (Screening mammogram progra	am and breast cancer initiatives.)			

Thank you for your support!