



California Hospice And Palliative Care Association

Yes, I want to support the work of the California Hospice and Palliative Care Association I enclose my/our gift of: ☐ \$500 ☐ \$100 ☐\$50 ☐ \$25☐ Other \$_____ ☐ Cash ☐ Check made payable to the California Hospice and Palliative Care Association ☐ Please charge my credit card a single payment of: \$______ Please establish a regular payment on my credit card of \$ ______ per month per quarter other Begin my payments on _____ through _____ Credit Card Information ☐ American Express ☐ MasterCard ☐ Visa Card #: _____ Exp. Date: _____ ID# _____ Name as it appears on the credit card: City: _____ State: ____ Zip: ____ This gift is: In Honor Of: In Memory Of: ______ This special person is my/our: ☐ parent ☐ spouse ☐ son ☐ daughter ☐ brother ☐ sister ☐ friend ☐ grandparent ☐ other _____ Please notify the following individual (s) of my gift: Address: _____ City: ______ State: _____ Zip: _____ Email: _____ Phone: _____ **Donor Information** Your Name(s): City: ______ State: _____ Zip: _____ Email: _____ Phone: _____ ☐ I would like information about how to include the California Hospice and Palliative Care Association in my will or estate plans.