COOPERSTOWN MEDICAL CENTER
Foundation

Cooperstown Medical Center Foundation Contribution Form

Name: ____

Address: ____

City: ___________________ State: ______ Zip: __________

Phone: ____

Email: ____

In Support of the Dakota Regional Medical Center, I/We are pleased to make the following contribution:

Enclosed is my gift of:

- **$50** ☐
- **$100** ☐
- **$500** ☐
- **Other** ☐ $__________

Make checks payable to CMC Foundation

_____Please contact me/us to make a gift through a will or trust, insurance or retirement assets, or gifts.

______I/We wish this gift to be given anonymously.

_________I/We would like to transfer securities. Please call me.

__________ Please contact me about contribution through Automatic Withdrawal from my bank account

Please use my gift for:

- _____Where Needed Most
- _____Care Center
- _____Hospital
- _____Clinic
- _____Other

Cooperstown Medical Center Foundation

107 12th Street S
Cooperstown, ND 58425

Phone: 701.786.1700, Ext 7108 Fax: 701.786.7121
E-mail: foundation@coopermc.com

Always here. Always near.

Tribute Gift:
I/We ____ **wish to provide this gift:**

In Memory or Honor of ____

On the Occasion of ____

Please send notice of our tribute gift to:

Name: ____

Address: ____

Revised: 04.06.2023/ks
S:/Forms/Foundation/Contribution Form