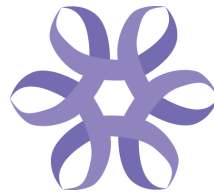


Donation Form



Cancer Center of
Western Wisconsin

Care Bags

Fund assists in the purchase of care bags filled with comfort items given to patients during their time of treatment.

General Fund

Fund devoted to furthering our efforts in providing high quality care to our patients.

Little Blessings

Fund dedicated to assisting patients through gift cards given for personal or family needs including date nights, salon appointments, gas purchases, etc.

Journey Garden

Fund supports the development and maintenance of the Journey Garden located behind the Radiation Therapy Center at Westfields Hospital & Clinic. The garden creates a space to reflect, recover and renew for patients, caregivers, & staff.

Specific Garden Items:

Tree	\$1000
Birdhouse	\$500
Butterfly House	\$500
Shrub	\$250
Engraved Paver Stone	\$225
Perennial Planting	\$100

On behalf of the many individuals who benefit from the programs at the Cancer Center of Western Wisconsin, we thank you for your donation. Much of what we do would not be possible without your contribution & commitment to quality care in Western Wisconsin.

Donation Information

This gift is: In Honor of In Memory of

Name _____

Thank you for your gift of support.

See Reverse Side

Cancer Center of Western Wisconsin

Amery Hospital & Clinic • Hudson Hospital & Clinic • Osceola Medical Center • Radiation Therapy Center of Western Wisconsin

St. Croix Regional Medical Center • Western Wisconsin Health • Westfields Hospital & Clinic



Personal Information

First Name _____

Last Name _____

Address _____

City/State/Zip _____

Phone _____

E-mail _____

Please send an acknowledgment of my gift to:

First Name _____

Last Name _____

Address _____

City/State/Zip _____

Please apply my gift to the following fund:

- Care Bags
- General Fund
- Little Blessings
- Journey Garden
- Specific Garden Item: _____

Personalization:

Each paver may be engraved with up to four lines, 18 characters per line, including spaces/punctuation.

Payment Method:

Check \$ _____

Payable to **Cancer Center of Western Wisconsin**

Card \$ _____ MasterCard Visa

Name as it appears on card _____

Signature _____

Card Number _____

Expiration (Month/Year) _____ Security Code _____

Please send completed form along with payment to:

Cancer Center of Western Wisconsin
 501 Hospital Road, New Richmond, WI 54017