Mercy College of Health Sciences
c/o Des Moines Foundation
411 Laurel St., Ste. 2250
Des Moines, IA 50314
515-643-6609

Statement of Gift Intent for Joyce E. Lillis School of Nursing

Name: _____

Address: _____

City, State, Zip Code: _____

REQUIRED Gift Information:

I/We wish to establish a gift in the amount of _____ over ◯1 ◯3 ◯5 years.

Please accept my/our initial payment of: $_____ (payment must be attached.)

with a remaining balance of: $_____ to be paid as follows:

Number of payments _____
Paid: ◯**Monthly** ◯**Quarterly** ◯**Annually** **Beginning on:** _____
(Reminders will be mailed to you at the frequency you indicated above.) *MM/DD/YY*

DONOR RECOGNITION:

☐ Please list my (our) name as specified below:

Name(s): _____
(Please print above exactly as you would like your gift to be recognized. Examples: John H. & Mary K. Smith, The Family of John Smith, In honor/memory of John Smith, John & Mary Smith, Dr. John & Mary Smith)

☐ I/We wish that our gift be treated as an anonymous donation.

☐ I/We are interested in naming recognition within the Joyce E. Lillis School of Nursing.
(A limited number of Named Spaces are available)
Space Reserved: _____

FULFILLMENT OPTIONS:

☐ I/we will make my/our gift through the ◯United Way of Central Iowa
◯Community Foundation of Greater Des Moines

☐ Enclosed is my check in the amount of: $_____
(Payable to MercyOne Des Moines Foundation.)

☐ Please charge my/our credit card listed below in the amount of: $_____
◯American Express ◯Discover ◯MasterCard ◯Visa
Card Number: _____ Expiration Date: _____

☐ I/We ~~wish to~~ give stock/securities: No. of Shares: _____ Name Ticker: _____
Stock transfer instructions are available upon request for you or your broker.

$_____ of this gift will be paid by a matching gift program at _____

Donor(s) Signature(s) _____ Date: _____

Volunteer/Staff Signature: _____ Date: _____

Thank you for making an impact on healthcare through your support of the Joyce E. Lillis School of Nursing at Mercy College of Health Sciences.