

Please print, complete and return this form to:

East Hampton Healthcare Foundation  
200 Pantigo Place, Suite M  
East Hampton, NY 11937

YES, I/WE WANT TO SUPPORT THE EAST HAMPTON HEALTHCARE CENTER PROGRAMS!  
PLEASE ACCEPT MY/OUR PLEDGE FOR:

- |                                   |                                   |                                    |  |
|-----------------------------------|-----------------------------------|------------------------------------|--|
| <input type="checkbox"/> \$50,000 | <input type="checkbox"/> \$25,000 | <input type="checkbox"/> \$10,000  | <input type="checkbox"/> \$5,000       |
| <input type="checkbox"/> \$1,000  | <input type="checkbox"/> \$500    | <input type="checkbox"/> \$250     | <input type="checkbox"/> OTHER\$ _____ |
| TERM:                             | <input type="checkbox"/> one year | <input type="checkbox"/> two years | <input type="checkbox"/> three year    |

I/WE WOULD RATHER ENCLOSE A CONTRIBUTION OF \$ \_\_\_\_\_  
PLEASE MAKE ALL CHECKS PAYABLE TO THE  
EAST HAMPTON HEALTHCARE FOUNDATION

Name: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_  
Phone: ( ) \_\_\_\_\_ Email: \_\_\_\_\_

For more information  
please call the  
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East Hampton  
Healthcare Foundation  
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Fax: 631-907-0105  
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11937