



Belmont County Capital Campaign

DONOR INFORMATION

Name	
Home Address	
City	
State	
Zip Code	
Phone Number	
Email	

PLEDGE INFORMATION

I pledge a total of \$_____ to be paid:

Now \$_____/month \$_____/quarter \$_____/annually

Recurring invoice to be sent/start: _____ (month & date)

I plan to make this contribution in the form of:

Cash Check Credit Card Payroll Deduction

Please call the Marketing and Development office at 740.283.7241 for all credit card donations.

CAPITAL CAMPAIGN FUNDS

Your contribution will be restricted to the Belmont County Capital Fund.

NAMING RIGHTS

My donation qualifies for naming rights in the Neighborhood Hospital. (\$10,000 and above).
The Foundation will reach out to you to complete the dedication details before any plaque processes are finalized.

ACKNOWLEDGEMENT INFORMATION

Please use the following names in all acknowledgements:

I (we) wish to have our gift remain anonymous.

Signature(s): _____ Date: _____

THANK YOU FOR YOUR DONATION!

Please return to: Trinity Health System Foundation Office | 380 Summit Ave. | Steubenville, OH 43952
foundation@trinityhealth.com | Fax: 740.283.7538