

Mercy Foundation North

Mercy Medical Center Mt. Shasta

Pledge Statement

Print Full Name: _____

Address: _____

City, State, Zip: _____

Phone: Home: _____ Work: _____

I pledge to Mercy Foundation North, the sum of \$ _____ to be paid over a period of ____ year(s) for the benefit of the _____ project and/or Department at _____ Facility.

First payment will be made in (month) _____ of (year)_____.

Please send pledge payment reminders: (Check One) Annually Quarterly Monthly

PAYMENT OPTIONS:

I wish to pay by check. Please make checks payable to "Mercy Foundation North."

I wish to pay by Credit Card. Credit Card authorization (for initial payment):

Visa Mastercard Discover

Card # _____ Exp. Date _____

Signature _____ Three digit Security Code: _____

Signature _____

Date _____

For further information, please call Mercy Foundation North at (530) 247-3424.

**Please return completed, signed, and dated form to:
Alisa Johnson, MFN Siskiyou County Development Officer, MMCMS-Rm. 19
via interoffice mail
or postal mail addressed to:
Mercy Foundation North, Mercy Medical Center Mt. Shasta, 914 Pine Street, Room 19,
Mt. Shasta, CA 96067.**