



Pledge Form

Donor Information (please print or type)

Name: _____
Billing address: _____
City: _____ State: _____ Zip: _____
Telephone (home): _____
Telephone (business): _____
Fax: _____
E-Mail: _____

Pledge Information

I (we) pledge a total of \$_____ to be paid: Now Monthly Quarterly Annually

I (we) plan to make this contribution in the form of: Cash Check Credit Card Other

Credit Card Type: MasterCard Visa

Credit Card Number: _____ Expiration Date: _____

Authorized Signature: _____

Gift will be matched by _____ (company/family/foundation).

Form enclosed Form will be forwarded

Acknowledgement Information

Please use the following name(s) in all acknowledgements:

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

Signature:	
Signature:	
Date:	

Please make checks, corporate matches, or other gifts payable to:

North Side Christian Health Center
816 Middle Street
Pittsburgh, PA 15212