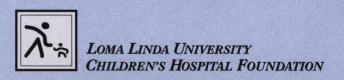
## **Donation form**

growing

special



Shining Star **Funds** 

	Mattnew Stamp	
lootings	Your Name	
lasting	Father Your Relationship To This Person	
1	Address 10244 Arrow Rte Apt 108	
touching	Rancho Cucamonga	California
	City	California State Zip Gode
91730		
precious	Phone E-mail	
You may wish to photocopy this donation Form and circulate it to other pe		and circulate it to other people.
Monthly Gift		
To help support the work of Loma Linda University Children's Hospital Foundation and as a contribution to this Fund, I will		
make a tax-deductible contribution each month for the following amount (minimum \$5.00):		
<b>810</b>	<b>3</b> \$15	□ \$100 □ Other \$
AUTOMATIC CREDIT/DEBIT CARD. I authorize Loma Linda University Children's Hospital Foundation to charge my		
credit card each month for the amount noted above according to the terms of agreement below.		
Visa MasterCard American Express Discover		
Card No. Expiration date		
Name of cardholder		
Signature		Date signed
OR At present I would prefer to make a Single Gift of: \$		
I enclose my (please check box) Check Money Order made payable to Shining Star Fund.		
OR		
Please charge my:	Visa MasterCard American Express	Discover
Card No. Expiration date		
Name of cardholder		
Signature		Date signed
orginature L		Date signed
	y authorization to charge my credit card or transfer my monthly pledge amount f	
Loma Linda University Child	ren's Hospital Foundation in writing that I wish to end this agreement and Loma	Linda University Children's Hospital Foundation has had

Robert Matthew Carroll-Stamp Shining Star Fund

Please return this form to:

Loma Linda University Children's Hospital Foundation, 11175 Mountain View Avenue, Suite A, Loma Linda, CA 92354

Keep this receipt for your records. Thank you for your help.

a reasonable time to act on it. A record of each payment will be included on my monthly bank or credit eard statement and will serve as my receipt.

TERMS OF AGREEMENT: My authorization to charge my credit card or transfer my monthly pledge amount from my bank account shall remain in effect until I notify Loma Linda University Children's Hospital Foundation in writing that I wish to end this agreement and Loma Linda University Children's Hospital Foundation has had a reasonable time to act on it. A record of each payment will be included on my monthly bank or credit card statement and will serve as my receipt.

Amount per month \$. Date signed