

The ROCKBRIDGE AREA HOSPICE mission is to treat, comfort and provide supportive care to terminally ill persons to enable them to live life fully. This organization is sustained through the donations of individuals and organizations. If you wish to contribute, please complete this form so that we may thank you personally and acknowledge your gift when appropriate.

Given by: Mr. \_\_\_ Mrs. \_\_\_ Ms. \_\_\_ Organization: \_\_\_  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

\_\_\_\_\_ GENERAL DONATION

\_\_\_\_\_ IN MEMORY OF \_\_\_\_\_  
.....Send acknowledgment to \_\_\_\_\_  
.....Address \_\_\_\_\_  
.....City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
.....Relationship to Deceased \_\_\_\_\_

\_\_\_\_\_ IN LIVING HONOR OF \_\_\_\_\_  
.....Send acknowledgment to \_\_\_\_\_  
.....Address \_\_\_\_\_  
.....City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
.....Relationship to Person Honored \_\_\_\_\_

\_\_\_\_\_ OTHER (Please Explain) \_\_\_\_\_  
\_\_\_\_\_

PLEASE HELP US TO USE YOUR MONEY WISELY . . .  
If your address is incorrect or duplicated on our mailing list, let us know:

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

PLEASE RETURN THIS FORM TO:

ROCKBRIDGE AREA HOSPICE  
P. O. BOX 948  
LEXINGTON, VIRGINIA 24450