



Children's Hospital of Wisconsin®

A member of Children's Hospital and Health System.

Children's Hospital and Health System Foundation
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N.E.W. 1.5k mlk



A MAGICAL EVENING



- Yes, I/we will attend.
_____ Number attending.
Please indicate your name and the names of your guests in the space provided.
 - Tables of 10 are \$750.
 - Tables of eight are \$600.
 - Individuals are \$75.

Make checks payable to Children's Hospital and Health System Foundation (CHHSF). An additional donation of \$ _____ is enclosed.

- I/We are unable to attend.
Enclosed is my/our donation of \$ _____ .
- My employer has a matching gift program.

Your name _____
(Please print first and last name.)
Address _____
City _____ State _____ ZIP _____
Daytime phone with area code (_____) _____ - _____
E-mail (optional) _____
Guest names (Tables seat up to 10 guests.):

(Please print first and last name of each person.)

The favor of a reply is requested by June 1, 2009. Mail this card in the envelope provided. For credit card payment only, you may fax your RSVP to (920) 831-6409.

Check/cash Visa MasterCard Discover AmEx

Account number
Expiration date _____ / _____ / _____
Signature _____