Please send or fax completed form to:
VACC Camp - Nicklaus Children's Hospital
3200 SW 6 0th Court - Suite 203
Miami, FL 33155
Phone: 305-662-8222 **Fax:** 786-268-1765

Donation Form

Donation Information

Amount $ _____

Please use my donation to support the endowment of the Ventilator Assisted Children's Center. (VACC)

Personal Information

Title (Please select one) ❑ Mr. & Mrs. ❑ Miss ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr.

First Name _____ Middle Initial _____ Last Name _____

❑ Home Address ❑ Business Address -- Company Name _____

Street _____ Apartment or Suite Number _____

City _____ State _____ Zip _____

Phone: Home ( ) _____ Business ( ) _____ Cell ( ) _____

Email address: _____ ❑ Yes ❑ No I would like to receive email updates

Donation Method

❑ Credit Card ❑ Check (Please make checks payable to **MCHF-VACC CAMP**)

Credit Card Information

Select card type (Please select one) ❑ American Express ❑ Visa ❑ MasterCard ❑ Discover

Name as it appears on your credit card _____

Credit Card Number _____ Expiration Date (month/year) _____/_____

Signature_____

Employer Matching (optional)

❑ Yes, my employer will match my donation

Company Information

Company Name _____

Street _____ Suite Number _____

City _____ State _____ Zip _____ Phone ( ) _____

Tribute Gift Information (optional)

❑ I'd like to make this gift in memory of _____
❑ I'd like to make this gift in honor of _____

Notification that a tribute donation has been made will be sent to the person you indicate below:

First Name_____ Last Name _____

Street _____Apartment or Suite Number _____

City _____ State _____ Zip _____