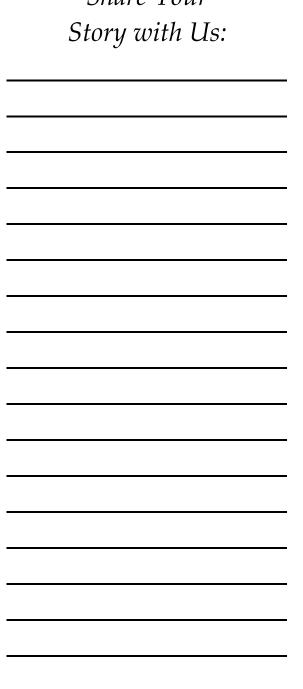
## Share Your







If you have received extraordinary

care, please consider recognizing

the staff member, department or

physician by making a Guardian

Angel Program donation in their

honor.

Recognizing Your Guardian Angel

Please detach and return

Plumas Health Care Foundation Guardian Angel Program

tion is proud oportunity to through the This program ways. It gives y to recognize bers. It also Health Care ed to continue the ability of provide community.

In recognition of your gift, your Guardian Angel will receive a certificate of appreciation informing him/her of your gratitude. In addition, Guardian Angels receive a lapel pin to wear proudly as a token of the excellent care you received.



Plumas Health Care Founda
to offer our patients an op
express their gratitude t
Guardian Angel Program. T
serves our hospital in two w
patients a unique opportunity
our remarkable staff memb
provides the Plumas H
Foundation with funds neede
our mission of enhancing t
Plumas District Hospital
quality healthcare to our local



Yes, I would like to participa	te in the Guardian Angel Pr	Yes, I would like to participate in the Guardian Angel Program by making a gift to the Plumas Health Care Foundation.
rour Iname:		I wish to remain anonymous
Address:		Phone:
City, State, Zip:		Email:
Name of individual or department you would like to honor:	tment you would like to ho	nor:
Payment Information:		
Donation amount:   \$25	$\square$ \$50 $\square$ \$100 $\square$ \$250	$\square$ \$100 $\square$ \$250 $\square$ Other, please specify \$
Payment Method:   Cash	□ Check ( <i>Make</i>	☐ Check (Make checks payable to Plumas Health Care Foundation)
If paying by Credit Card:   UISA		□ Mastercard Card Number
Expiration Date	Cardholder's Name	Signature

Plumas Health Care Foundation is a 501 (c) (3) non-profit organization. Charitable contributions are deductible as allowed by law. Please contact us if you do