Donation Form

Thank you for supporting Southside Medical Center.

Date:	Name:			
Company/Organization:				
Address:				
City:	State:		Zip Code:	
Phone: ( )	Best time to call: : ☐AM ☐PM			
Email:				
Payment Method: ☐Check ☐MasterCard ☐Visa	Amount of Gift:	$		
Credit Card #				
Expiration Date:	Month:	Year:		
Authorizing Signature for credit card				
This gift is made in memory of:				
This gift is made in celebration of:				
An acknowledgement should be sent to:				
Address:				
City:	State:	Zip Code:		

Please return this form to us at the address below:

Southside Medical Center
Attention: Administrative Office
1046 Ridge Ave. SW
Atlanta, GA 30315