

Introducing a Special Service... Just for You!

CITRUS VALLEY MEDICAL CENTER'S TWO CAMPUSES—222-BED INTER-COMMUNITY HOSPITAL IN COVINA AND 325-BED QUEEN OF THE VALLEY HOSPITAL IN WEST COVINA—HAVE PROVIDED TOP-QUALITY ROUTINE AND EMERGENCY MEDICAL CARE, RIGHT HERE IN YOUR OWN COMMUNITY, FOR DECADES.



Living in the East San Gabriel Valley, you or a family member have probably visited or been a patient at CVMC at least once.

And just as Citrus Valley Medical Center provides a lifeline to you, your family and your community in times of need, our donors provide our financial lifeline and enable us to offer these and many other life-saving and life-enhancing services.

As a FRIEND OF CITRUS VALLEY HEALTH FOUNDATION (FOF), your gift will help purchase much-needed life-saving equipment for Citrus Valley Medical Center.

To become a FOF, an annual tax-deductible contribution of \$500 or more will provide you with a *Friendship Card*.



As a holder of a *Friendship Card*, you and your spouse are entitled to a variety of special privileges:

- Expedited registration
- Simplified discharge
- A private room at no additional cost†
- A beautiful fresh-flower arrangement for the patient*
- A complimentary meal for a family member or friend*
- A daily newspaper*
- A personal visit by a Foundation staff member*
- A Foundation courtesy gift kit*

† Depending on availability.

* If an overnight stay is required.

Where else can you find a card that gives back to you—without interest rates and finance charges?

To be eligible for a *Friendship Card* and become a FRIEND OF THE FOUNDATION, please complete and return the simple application form that is attached.

For more information, contact Citrus Valley Health Foundation at 626/814-2421.

FRIENDS OF THE FOUNDATION FRIENDSHIP CARD APPLICATION

LEGAL NAME _____

HOME ADDRESS _____ CITY/STATE/ZIP _____

HOME PHONE (_____) _____ SOCIAL SECURITY NO.* _____

DATE OF BIRTH _____ PLACE OF BIRTH _____

OCCUPATION _____ EMPLOYER _____

EMPLOYER'S ADDRESS _____ CITY/STATE/ZIP _____

EMPLOYER'S PHONE (_____) _____

PRIMARY INSURANCE CO. _____

SUBSCRIBER _____ POLICY NO. _____

SECONDARY INSURANCE CO. _____

SUBSCRIBER _____ POLICY NO. _____

SPOUSE (FULL NAME) _____

DATE OF BIRTH _____ SOCIAL SECURITY NO.* _____

OCCUPATION _____ EMPLOYER _____

* Optional. Used to expedite registration.

Have you ever been admitted to Queen of the Valley or Inter-Community Hospital? Yes No

Has your spouse ever been admitted to Queen of the Valley or Inter-Community Hospital? Yes No

Amount of Annual Tax-Deductible Donation \$500 \$1,000 \$1,500 Other _____
 Send me an invoice annually for this amount

LIFETIME MEMBERSHIPS AVAILABLE. PLEASE CALL THE FOUNDATION FOR FURTHER INFORMATION.

VISA MC AMEX CREDIT CARD NO. _____ EXP. DATE _____

CHECK ENCLOSED Make check payable to Citrus Valley Health Foundation.

Return to: Citrus Valley Health Foundation • 1115 S. Sunset Ave. • West Covina, CA 91790

Please print clearly to assist us in verification of your information. We cannot process your *Friendship Card* until this application is returned and complete. Signatures and insurance cards are required upon hospital admission. All patient information will remain confidential per HIPAA regulations.

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