Restore & Renew Rockwell City Clinic Project

Donation & Pledge Form

Stewart Memorial Foundation | (712) 464-4247 | 1301 W Main St, Lake City, IA 51449 | stewartmemorial.org

DONOR INFORMATION

Donor Name(s):	
Mailing Address:	**City, State, ZIP:**
Phone Number:	**Email Address:**

GIFT COMMITMENT

Total Gift Amount:	Gift/Pledge Start Date:
I/we commit to making this gift for the Rockwell City Clinic Renewal Project as:	☐ One-time gift ☐ 1-year pledge ☐ 2-year pledge ☐ 3-year pledge ☐ Other:
Preferred Payment Frequency	☐ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly ☐ Other:

Donor Wall Recognition Levels	
1. $500,000 or greater	2. $250,000–$499,999
3. $100,000–$249,999	4. $50,000–$99,999
5. $20,000–$49,999	6. $10,000–$19,999
7. $5,000–$9,999	8. $2,500–$4,999
	9. $1,000–$2,499

RECOGNITION PREFERENCE

Please print your recognition name or memorial/honor designation as desired:
Examples: John and Susan Smith; John and Susan Smith Family; John and Susan Smith — in memory of Bob Smith

Please designate my gift in memorial of: ☐ Dr. Paul Knouf M.D. ☐ Dave McClain PA-C ☐ Veronica Schmidt R.N.

Naming Opportunity Interest: See page 2 for list of opportunities

☐ Please keep my donation anonymous. ☐ Please contact me about recognition or naming opportunities.

PAYMENT METHOD

☐ **Cash**
Amount $ _____

☐ **Check** Amount $ _____ Check # _____
Please make checks payable to Stewart Memorial Foundation and note Rockwell City Clinic Renewal Project in the memo line.

☐ **Stock or IRA Distribution** Tax ID #42-0860039
Estimated value $ _____ Stock/Security: _____ Shares/Units: _____
Please contact Stewart Memorial Foundation before initiating stock distribution for transfer instructions.

☐ **Gifts of Grain** New Cooperative Account #52095 or Landus Account #34725
Estimated value $ _____ Commodity: _____ Bushels/Quantity: _____
Elevator/Co-op of Delivery: _____
For gifts of grain, please contact Stewart Memorial Foundation before delivery so gift details can be coordinated. A grain storage receipt showing Stewart Memorial Foundation as the owner of the gift is required.

AUTHORIZATION

Donor Signature:	**Date:**
Stewart Memorial Representative:	**Date Received:**

RETURN INSTRUCTIONS

Please return completed forms to Stewart Memorial Foundation
Mail or deliver to 1301 W Main St, Lake City, IA 51449.
Questions? call (712) 464-4247 or email rjudisch@stewartmemorial.org

EMPLOYEE PAYROLL DEDUCTION OPTION

Employee Name:	Employee #:
☐ I authorize $ _____ to be withheld per pay period for _____ months, beginning _____.	Total donation $
☐ I authorize a one-time deduction of $ _____ to be withheld from my paycheck.	Date of deduction:

Naming Opportunities

Multi-Year Pledge Opportunity: Donors making gifts of $25,000 or more may choose to fulfill their commitment through a pledge schedule of up to five years, providing flexibility while helping transform healthcare services for generations to come.

Stewart Memorial Clinic Rockwell City

Area	Amount	Status
Clinic Waiting Area	$25,000	Reserved
Conference Room	$15,000	Available
Procedure Rooms (2)	$15,000	1 Reserved, 1 Available
Exam Rooms (10)	$10,000 each	Available
Employee Patio	$10,000	Reserved

Rehabilitation Services Facility

Area	Amount	Status
Building Name	$500,000	Available
Rehab Gym	$50,000	Reserved
Pediatric Treatment Area	$25,000	Available
Rehab Waiting Area	$25,000	Available
Treatment Rooms (4)	$10,000 each	Available