FAITH REGIONAL
HEALTH SERVICES

Dream Team

Print Name: _____

Department: _____

Campus Location: _____

Phone Number: _____

Email: _____

Date of Birth: _____

Home Address: _____

_____

☐ Yes, I would like to ***dream*** with you.
(Please choose the amount you would like to contribute to your designated dream area)

☐ 1 hour of my hourly wage per pay period
☐ 1/2 hour of my hourly wage per pay period
☐ $15.00 per pay period
☐ $_____ per pay period

My ***dream will be fulfilled*** through my contributions toward _____

(Please see below for gift designation options. If something is not listed that you would like your contribution to go toward, call Jackie Whipple, Foundation Coordinator at 644-7694)

Gift Designations

Acute Rehab
Anesthesia
Appearance Center
Area of Greatest Need
Asthma Clinic
Bed Addition
Carson Cancer Center
Cancer Center Education
Carson Cancer Center Vans
Cancer Resource Center
Clinical Trials for Cancer
Cardiac Services
Cardio Pulmonary Rehab
Clinical Decision Unit
Charity Care
Diabetic Center
Dialysis
Education
Employee & Medical Staff Education
Emergency Department
Endowments
- Carson Cancer Center
- Cardiac Services
- Dialysis
- Education
- Hospice
- St. Joseph's/Skyview Villa

Environmental Services
Guest Services
Healing Garden
Health Information
Health Resource Center
Home Health Care
Hospice
Hope Fund
Intensive Care Unit
Internships
Mammography
Meals for Families
Medical Equipment
NENCAC
Nursery
Nursing Services
Nutrition Services
Obstetrics
Orthopedics
Outpatient Clinic
Pallative Care
Patient Education
Patient Access/Escorts
Pediatrics
Performance Improvement
Pharmacy
Psychiatric Services
Quality and Med Staff Services
Radiology
Radiology & Nursing Scholarships
Recovery Room
Rehab Central
Respiratory Therapy
Social Services
Spiritual Care
St. Joseph's/Skyview Villa
Surgical Services
Wound Center

I authorize the above indicated contribution to the FRHS Foundation Dream Team. I understand that at any time I can increase, decrease or cancel my membership by contacting the Foundation Office. Depending on gift level, a portion of my gift is tax deductible.

Signature: _____ Date: _____

☐ Yes, you have my permission to use my name in hospital publications.
☐ No, I wish to remain anonymous.