

FOUNTAIN CENTERS

A Mayo Clinic Health System program for substance abuse and addiction

Your Name: _____

Address: _____

City/State/Zip: _____

This gift is

- ☐ **In memory of:** _____
- ☐ **In honor of:** _____
- (your gift amount will remain confidential)

Please notify: Name _____

Address _____

City/State/Zip _____

I wish to support the following program:

- ☐ **Garth Barker Memorial Scholarship Fund**
- ☐ **Dr. Mark Donaldson Patient Support Fund**
- ☐ **Future Building Development Fund**

Total Gift: \$ _____

- ☐ **Check – make payable to Mayo Clinic Health System – Albert Lea**
- ☐ **MasterCard/Visa #** _____
- Expiration Date:** _____

Signature: _____

- ☐ **Please make my gift to Fountain Centers anonymous**

Send to: Mayo Clinic Health System – Albert Lea
ATTN: Development Office
404 W. Fountain St.
South Annex, Room 1-119
Albert Lea, MN 56007