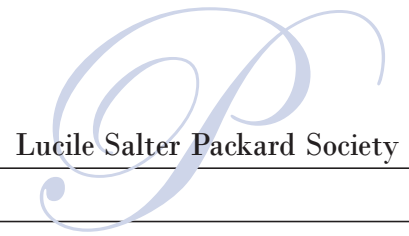


# Membership Application

(All information is treated confidentially)



## Please provide the following information:

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Phone \_\_\_\_\_ Email \_\_\_\_\_

### Optional:

Estate Planner/Attorney \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Phone \_\_\_\_\_ Email \_\_\_\_\_

**Yes, I included the Lucile Packard Foundation for Children's Health (Tax-ID#: 77-0440090) in my estate plans. Please indicate how you have provided for a distribution to the Foundation:**

\_\_\_\_\_ will                      \_\_\_\_\_ living trust                      \_\_\_\_\_ retirement plan assets  
\_\_\_\_\_ charitable gift annuity                      \_\_\_\_\_ charitable remainder trust                      \_\_\_\_\_ gift of life insurance  
\_\_\_\_\_ other (please specify): \_\_\_\_\_

**LSPS members are recognized in donor publications and on the Hospital donor wall.**

\_\_\_\_\_ Yes, please list my name in donor recognition materials as follows:  
\_\_\_\_\_  
\_\_\_\_\_ I wish to remain anonymous.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Please send your completed application to:

Office of Gift Planning  
Lucile Packard Foundation for Children's Health  
400 Hamilton Avenue, Suite 340  
Palo Alto, California 94301

For additional assistance, please call the Office of Gift Planning at (650) 724 – 5778.