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**SUMMIT**

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Check Donation  
Form

## Your Information

Name \_\_\_\_\_

Organization \_\_\_\_\_

Address \_\_\_\_\_

Email \_\_\_\_\_

Phone Number \_\_\_\_\_

## Team or Individual Fundraiser You Are Donating To (If Applicable)

Name \_\_\_\_\_

You may address your check to Summit Health Cares and mail it to us with this form attached.  
P.O. Box 992 New Providence NJ 07974