Guardian Angel

gifts can be any size.

There is no minimum or maximum donation amount to honor your caregiver(s). A recognition ceremony is held for every Guardian Angel gift – giving special honor to those who go above and beyond. Every Guardian Angel receives a message of thanks and a lapel pin to wear proudly.

"With all our hearts, we wish to thank two special UnityPoint Hospice caregivers. Your hearts are GOLD."

Guardian Angel Donor

NO POSTAGE NECESSARY IF MAILED IN THE UNITED STATES

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO. 144 CEDAR RAPIDS, IA

POSTAGE WILL BE PAID BY ADDRESSEE

ST. LUKE'S HEALTHCARE FOUNDATION
PO BOX 3026
CEDAR RAPIDS IA 52406-9927

☐ Please check if this is a new address

St. Luke's Foundation's mission:

Support
UnityPoint Health – Cedar Rapids
in giving the health care we'd like our loved ones to receive.

UnityPoint Health
St. Luke's Foundation

PO Box 3026
Cedar Rapids, IA 52406-9927
(319) 369-7716

stlukesfoundation.com

000141a.cr-5 5/22 CS

A way to say thank you to your caregiver

Guardian Angel Program

UnityPoint Health® – Cedar Rapids

UnityPoint Health
St. Luke's Foundation

A gift of gratitude that says

Thank you!

Many patients and their loved ones express their gratitude through smiles and letters of thanks. The Guardian Angel program at UnityPoint Health – Cedar Rapids offers another way for grateful patients and families to recognize a doctor, nurse, housekeeper, volunteer or other caregiver who made a positive difference in their lives.

Donations received through the Guardian Angel program pay tribute to caregivers who have enriched your life while also helping to fund programs and equipment that add to the quality of care right here in our community.

Angels AMONG US
GUARDIAN ANGEL PROGRAM

REMOIST GLUE STRIP

Yes, I wish to make a gift and thank my Guardian Angel!

Please complete the form below or visit **stlukesfoundation.com** and click the Guardian Angel program link to donate online.

I would like to donate $_____ to honor my Guardian Angel(s).

Please direct my gift to:

☐ Area of greatest need

☐ St. Luke's Department: _____

☐ UnityPoint Clinic

Caregiver name(s) and Department/Clinic
(last names not required)

_____

_____

_____

_____ __

Date(s): _____

(Enclose additional comments if needed.)

Message to caregiver(s):_____

_____

_____

_____

_____

Please make checks payable to: St. Luke's Foundation

Donor information:

Name: _____

Address: _____

City: _____

State: _____ Zip Code: _____

E-mail: _____

Phone: _____

☐ I agree to allow UnityPoint Health to use my name and written comments in hospital and foundation publications.

☐ Please remove me from your mailing list. *Provide your name and address above for verification purposes.*

glued envelope

glued envelope