HARRISBURG MEDICAL CENTER FOUNDATION BRICK FUND

P.O. Box 428 – Harrisburg, Illinois 62946 – (618) 253-7671, ext. 369

ENGRAVED BRICK ORDER FORM

Name ________________________________ Address ____

City __________________________________ State __________Zip _____________________

Phone __________________________________

Please engrave a brick with the following inscription:

(Only 3 lines with a maximum of 14 characters per line. Spaces and punctuation each count as a character. Please print or type your inscription.)

Cost of Engraved Brick: $100. Make checks payable to: Harrisburg Medical Center Foundation.

Paid by Check ☐ Cash ☐

Customer's Signature ____ Date ____________________________