

Lights of Love ORDER FORM

Each Light is a \$5 Donation.
(PLEASE PRINT)

Honoree's Name	Send card to:	Address, City, State, Zip	How you wish card signed:

Your Name: _____

Address: _____

City: _____

State: _____ Zip: _____

Phone () _____

e-mail _____

Total amount enclosed: \$ _____

Names received after Thursday, Dec. 1st by 4:00pm, cannot be guaranteed a listing by the time of the lighting ceremony.

Please make check payable to:

Marion Health

MAIL TO:

Lights of Love

Marion Health
441 N. Wabash Avenue
Marion, IN 46952-2690