

**PLEASE SHARE WITH
US WHY YOU WANT TO
THANK YOUR CARE
PROVIDER.**



I WANT TO THANK: _____
(PLEASE INCLUDE COMPLETE NAME OF CARE PROVIDER OR
HOSPITAL DEPARTMENT YOU WISH TO THANK.)

DATE OF CARE PROVIDED: _____

ROOM NUMBER: _____
(THIS WILL HELP IN THE IDENTIFICATION OF YOUR CARE
PROVIDER IF YOU CAN'T REMEMBER HIS/HER NAME.)

HE/SHE WAS SPECIAL BECAUSE:

**GRATEFUL
PATIENT**



**WHMS FOUNDATION
PO BOX 214
ATKINSON, NE 68713**

**MARKETING@WESTHOLTMED.ORG
WWW.WESTHOLTMED.ORG
402.925.1956**

**WEST HOLT MEDICAL SERVICES HAS
PERMISSION TO USE THE CONTENTS OF
MY THANK YOU FOR
PUBLICATIONS.**

YES _____ NO _____

**Grateful
Patient**

**"MAKING A DIFFERENCE
EVERYDAY"**



Grateful Patient

GRATEFUL PATIENT PROGRAM

Our patients often ask how they can express their appreciation for the remarkable care they received at West Holt Medical Services. Many send a letter of thanks but would like to do more. The Grateful Patient Program offers patients and their families a way to say "thank you" to a special care provider and at the same time support a program of their choice.

In recognition of this gift, the care provider will be presented with a starfish lapel pin.



THE STARFISH STORY

An old man walked up a shore littered with thousands of starfish, beached and dying after a storm. A young man was picking them and flinging them back into the ocean. "Why do you bother?" the old man scoffed. "You're not saving enough to make a difference." The young man thought for a moment, then picked up another starfish and sent it spinning back into the water. "Made a difference to that one" he said.

Adapted from "The Star Thrower" by Loren Eiseley

IF YOU HAVE QUESTIONS REGARDING THE GRATEFUL PATIENT PROGRAM PLEASE CONTACT THE FOUNDATION OFFICE AT 402.925.1956 MARKETING@WESTHOLTMED.ORG.

**YES, I WANT TO MAKE A GIFT TO SAY
THANK YOU
FOR THE SPECIAL CARE YOU GAVE TO ME!**

ENCLOSED IS MY GIFT OF: (PLEASE CIRCLE ONE)
\$25 \$50 \$100 \$250 \$500
\$1000 OTHER _____

PLEASE DIRECT MY GIFT TO: (PLEASE CHECK ONE)
___ GREATEST NEED AREA
___ DEPARTMENT

(DEPARTMENT NAME)

NAME

MAILING ADDRESS

CITY STATE ZIP

PHONE

EMAIL ADDRESS

PLEASE MAKE YOUR CHECK PAYABLE TO:
WEST HOLT MEDICAL SERVICES FOUNDATION
PO BOX 214
ATKINSON, NE 68713



Please note: Your gift amount will be kept confidential and will not be shared with the person(s) you are thanking.