CENTER FOR FAMILY HEALTH

Opening the door to health care for all

Donation Form

Name ____

Address ____

City _____________________________________ State ________________ Zip __________

Phone _____________________________________

I want to help!:

Donation Designation

☐ Building Campaign ☐ General Purposes ☐ Dental Care ☐ Prenatal Care

☐ Diabetic Supplies ☐ Pediatric Care ☐ School- Based Health

Payment by Check:

☐ I want to make a one-time payment in the amount of $_________. My check is enclosed

☐ I pledge $________. Please send me monthly reminders so I may send you a check every month. My first monthly payment of $_________ is enclosed.

Payment by Credit Card:

☐ Please bill my credit card for a one-time payment of $_________

☐ I pledge $________. Please bill my credit card on the first of every month in the amount of $________ for the next _______ months.

Name on Card ____

Card Number _________________________________ Exp Date ___________ CSC Code _____

Signature ____________________________________ ☐ Visa ☐ MasterCard