



"Providing quality family centered primary health care services to individuals who have inadequate access since 1979."



**COMMUNITY HEALTH CENTERS, INC. DONATION FORM**

Yes, I want to partner with CHC to provide access to quality health care for the uninsured of Salt Lake County!

Table with 3 columns: INSTRUCTIONS, RETURN FORM TO: (Community Health Centers, Inc. address), and an empty column.

Donor Name: \_\_\_\_\_
Street: \_\_\_\_\_
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
Phone: \_\_\_\_\_ Email: \_\_\_\_\_
Enclosed is a gift in the amount of: [ ] \$50 [ ] \$100 [ ] \$150 [ ] \$200 [ ] \$250 [ ] other

Please make checks payable to: **Community Health Centers, Inc.**

Please charge my credit card: [ ] Visa [ ] MasterCard
Card number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_
Name as it appears on card: \_\_\_\_\_
SecCode (3-digit code on back of card: \_\_\_\_\_
Signature: \_\_\_\_\_

- [ ] I'd like to donate anonymously.
[ ] I would like to include CHC in my estate plans.
[ ] I'd like a tour of a clinic.
[ ] I'd like to find out more about becoming a board member.
[ ] I'd like to opt out of receiving communication & correspondence from CHC.

Make my gift a memorial or honorary tribute.
[ ] In memory of: \_\_\_\_\_
[ ] In honor of: \_\_\_\_\_
[ ] Commemorating: \_\_\_\_\_

Please send an acknowledgement card to:
Name: \_\_\_\_\_
Street Address: \_\_\_\_\_
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_