Donation Form

Name: ____

Address: ____

____

I would like to make a *one-time* donation of $____________________________

I would like to make a *quarterly* donation of $____________________________

I would like to make a *monthly* donation of $_____________________________

If you would like to donate by credit card please provide the following information:

Card Numbers: _______________________________ CVV: ________ Expiration: ____________

I, ______________________________, give permission for Community Health Clinic to process my credit card as indicated above. ____

(Signature) (Date)

Please make checks payable to **Community Health Clinic** and return with this form to:

1113 Woodland Dr. Elizabethtown, Ky. 42701. THANK YOU!

*The Community Health Clinic is a **501 (c) (3)** nonprofit organization. All donations are **tax deductible**.*

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