LA CLINICA

DONATION FORM

Donor Information

Name _____ Date_____

Company Name (if applicable) _____

Street Address _____ City _____ Zip_____

Day Phone _____ E-mail Address _____

Signature _____

Contribution Information

I / we would like to support La Clinica with a gift in the amount of $_____

I / we would like to make my contribution in the following manner:

□ Payment enclosed

□ As a one-time gift that I will send on the following date: _____ (we will send you a reminder)

□ Over a period of time—please bill me according to the following schedule:

□ Annually (_____) □ Semi-annually (_____& _____) □ Other _____
Month Month Month

□ Through La Clinica's Direct Assistance Plan. This plan allows contributions over time. With your authorization we will automatically withdraw a specified amount from your checking account or make a charge to your credit card according to the schedule of your choosing.

Pre-authorized contribution of $ _____ per month for _____ months

□ Checking Account (Please submit a voided check)

□ Credit Card (Please complete credit card section below)

Payment Method

☐ Check enclosed (please make check payable to La Clinica)

☐ Credit Card ☐ Visa ☐ MasterCard

Name as it appears on card: _____

Credit card number _____ Expiration date _____

Security Code _____

(Located on back of card in the signature section and is comprised of the last three numbers after your card number)

Other Information

☐ My, or my partner's, employer will match my gift (please contact me for more details)

☐ I would like information about La Clinica's planned giving programs

☐ I wish for my gift to remain anonymous

☐ I wish to be recognized in the following manner: _____

Mailing Information

Please mail this form and any contribution to La Clinica at 3617 S. Pacific Highway Medford, OR 97501

Thank you for your support!

La Clinica del Valle Family Health Care Center, Inc is a 501 (c) (3) non-profit organization
Tax ID: 94-3096772
All gifts are tax deductible to the full extent of the law

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