

DONATION FORM

Donor information Name Company name (if applicable) City State ZIP Street address _____ 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 (if using credit card, please complete the credit card section below) ☐ 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) □ Visa □ MasterCard □ Discover □ American Express ☐ Credit Card Name as it appears on card: Credit card number _____ Expiration date (located on back of card) Security code Other information ☐ I would like my gift to support: _____ (undesignated gifts will be used for general support). ☐ This gift is in honor, memory, or support of: • Please notify the following person of my gift (please include their phone number and address): ☐ 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 to remain anonymous.

Mailing information

Please mail this form and your contribution to La Clinica at 931 Chevy Way Medford, OR 97504.

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