LA CLINICA
AFFORDABLE HEALTH CARE EXCELLENCE FOR ALL

DONATION FORM

Donor information

Name_____ Date_____
Company name (if applicable) _____
Street address _____ City_____ ZIP _____
Day phone_____Email 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)

☐ **Credit Card** □ Visa □ MasterCard □ Discover □ American Express
Name as it appears on card: _____
Credit card number _____ Expiration date _____
Security code _____ (located on back of card)

Other information

☐ I would like my gift to support: _____ (undesignated gifts will be used for general support).

☐ 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.

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

Mailing information

Please mail this form and your contribution to La Clinica at 3617 S. Pacific Highway Medford, OR 97501.
Thank you for your support!