CARE 4 U
COMMUNITY HEALTH CENTER
"Because We Care!"

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Website: care4uchc.org

DONATION FORM

Please help Care 4 U Community Health Center (C4UCHC) fulfill our mission to meet the unmet needs of individuals and families to build a healthier community. Bringing us closer to our vision of equitable access to health care and optimum health outcomes to eliminate health disparities. **ALL DONATIONS ARE TAX DEDUCTIBLE!** C4UCHC is a registered tax-exempt non-profit organization with the Internal Revenue Service. (FEIN 46-4769097) (Florida Solicitation Registration #CH59291)

Yes! I would like to help C4UCHC in its mission:

My donation is: ☐ Monthly ☐ Annually ☐ One Time

In the amount of: ☐ $25.00 ☐ $50.00 ☐ $75.00 ☐ $100.00 ☐ Other: _____

My payment method is: ☐ Cash ☐ Check ☐ Credit Card

BILLING INFORMATION

Name: _____

Address: _____

_____ _____ _____
City State Zip Code

Phone Number: _____ Email Address: _____

CREDIT CARD AUTHORIZATION

Unless I checked, "One Time" above, I authorize **C4UCHC** to charge my Credit Card until I send a written notice of any change or termination.

☐ AMERICAN EXPRESS ☐ DISCOVER ☐ ☐ VISA

Credit Card Number: _____ Expiration Date: _____/_____

Verification Code _____ this is the last 3-digits of the number printed on the **back** of your Visa or MasterCard in the signature strip section. On an American Express card, this is a 4-digit number printed right above the end of your account number on the front of your card.

Signature: _____ Date: _____