



DONATION/PLEDGE CARD

Name: _____ Address: _____

City: _____ State: _____ Zip: _____ EMail: _____

Home Phone: _____ Office Phone: _____ Cell Phone: _____

I would like to:

- Make a One Time Donation of \$ _____
- Make a Monthly/Quarterly Donation of \$ _____ Monthly Quarterly
- Provide Dental Care for One Patient Per Month, \$50.00 _____
- Provide Medical Care for One Patient Per Month, \$35.00 _____
- Provide Vision Care for One Patient Per Month, \$40.00 _____
- Provide Physical Therapy for One Patient Per Month, \$20.00 _____
- Make an In-kind Donation: _____
- Provide _____

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