care resource

Your Community's Source for Healthcare

DONATION FORM

Thank you for supporting Care Resource. Your contribution will make a direct impact in our ability to continually expand our services and provide quality healthcare for all who need it.

Donation Amount

Select the amount of your donation below:

- ☐ $25
- ☐ $50
- ☐ $100
- ☐ $150
- ☐ Other (Specify Amount: $_____)

Designation

Specify where you would like your donation to go

- ☐ Where it is needed most
- ☐ Capital Campaign
- ☐ Food for Life Network Food Bank
- ☐ Other (Specify Designation: _____)

Tribute Gift

This gift is in honor, memory, or support of someone.

- ☐ In honor of ☐ In memory of ☐ In support of
- ☐ Person's name (_____)
- ☐ Please notify the following person of my gift
  - Specify name and address or email: (_____)

☐ **Enclosed is my check**

☐ **I would like to pay by credit card**

Payment Details

Cardholder name: _____

Cardholder number: _____

Expiration date: _____

Card security code (CSC): _____

Cardholder signature: _____

Email & Phone: _____

Address: _____

City, State, Zip & Country:

_____

Company Matching Gifts

☐ This gift can be matched Matching Company Name: _____

Please fill out this form and send it with your donation to:

Care Resource Community Health Centers c/o Development
3801 Biscayne Boulevard, Suite 220
Miami, Florida 333137