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
- $500
- Other (Specify Amount: $__________)

Designation

Specify where you would like your donation to go

- Where it is needed most
- Capital Fund
- Emergency Assistance Fund
- Food for Life Network Food Pantry
- Other (Specify Designation: ____________________________________)

Tribute Gift

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

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

Billing Address

Name: ___________________ Email: ____________________

Phone: ___________________ Country: ____________________

Address: ____

City: ___________________ Zip: ___________________

State: ___________________

Payment Details

Cardholder name: ____

Cardholder number: ____

Expiration date: __________ Card security code: __________

Cardholder signature:

____

Company Matching Gifts

- This gift can be matched
- Matching Company Name: ___________________

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

Care Resource Community Health Centers c/o Development
3801 Biscayne Blvd, Suite 220
Miami, FL 33137

MIAMI-DADE COUNTY

Midtown
3801 Biscayne Blvd.
Miami, FL 33137
T: 305.576.1234
F: 305.571.2020

Little Havana
1901 S.W. 1st Street
3rd Fl.
Miami, FL 33135
T: 305.203.5230
F: 305.203.5231

Miami Beach
1680 Michigan Avenue
Suite 912
Miami Beach, FL 33139
T: 305.534.0503
T: 305.673.3555
F: 305.538.4090

BROWARD COUNTY

Fort-Lauderdale
871 West Oakland Park Blvd.
Ft Lauderdale, FL 33311
T: 954.567.7141
F: 954.565.5624

Oakland Park
3160 Powerline Road
Oakland Park, FL 33309

www.CareResource.org
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