



Community Health Center Donation Form

Donor Information

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

Donation Information

Donation amount: \$_____

Please charge my credit card: American Express Visa Mastercard Discover

Credit Card#: _____ Expiration: _____ CVV: _____

Checks can be made out to Community Health Center.

Signature: _____ Date: _____

I would like more information about making monthly recurring donations to CHC

My donation is made in Memory / Honor (circle one) of: _____

All gifts are tax-deductible to the extent allowed by law.

Please return form to:
Community Health Center
Office of Advancement
107 Commercial Street
Mashpee, MA 02649

If you have any questions, please contact cellis@chcofcapecod.org or (508) 477-5990.

Thank you for your support to help CHC achieve our mission!

To donate online, please visit CHCofCapeCod.org/donation