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 to make a monthly donation as a *CHC Compassionate Health Supporter*

____ I would like information about making a lasting planned gift as part of *CHC's Legacy Society*

____ 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**