RCHN Community Health Foundation, Inc.

55 BROADWAY, SUITE 1502
NEW YORK, NY 10006

Phone (212) 246- 1122 Fax (212) 558-6580

DONATION FORM

Please fill out both pages of this form, and mail to:

RCHN Community Health Foundation
55 Broadway, Suite 1502
New York, NY 10006

RCHN Community Health Foundation provides the resources that help community health centers to thrive locally while disseminating best practices more broadly. Your gift to RCHN CHF ensures the advancement of the Foundation's signature programs and research, which translates into extraordinary care nationally for those in greatest need.

PERSONAL INFORMATION

Salutation (Ms., Mr., Dr., etc.): _____

Donor Name: _____

Address: _____

City: _____ **State:** ___ **Postal Code:** _____

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GIFT INFORMATION

□ One-time Gift □ Recurring Monthly Gift*

□$5,000 □$1,000 □$500 □$250 □$50 □$35 □Other _____

*By signing below, you authorize the RCHN Community Health Foundation to automatically process your gift as a secure credit card or direct debit transaction each month (please include account information below). We will continue to process your monthly gift until you ask to discontinue your participation, which you can do at any time by calling (212) 246- 1122.

I HAVE READ, UNDERSTOOD, AND ACCEPT THIS AGREEMENT:

Signature:_____

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Is this gift dedicated in honor or memory of someone?

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If you would like us to send notification of your gift, please enter in the name and address in the fields below of the person to be notified. You, the donor, will receive a tax receipt and gift acknowledgement sent to the address provided above.

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BILLING INFORMATION

I am making my gift by:

□ Check (payable to RCHN Community Health Foundation, Inc.)

□ Credit Card: □ Mastercard □ Visa □ Discover □ American Express

Credit Card Information

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