La Clínica
a california health+ center
www.laclinica.org

DONATION FORM

PRINT FORM

RESET FORM

Yes, I want to help provide affordable health care for children and families. Enclosed is my gift of:

☐ $10,000* ☐ $5,000* ☐ $2,500* ☐ $1,500* ☐ $1,000*

*Eagle Society Member (see website for benefits)

☐ $500* ☐ $250 ☐ $100 ☐ $50 ☐ Other $ _____

First Name: _____ Last Name: _____

Email: _____ Business/ Agency (if applicable): _____

Street Address: _____

City: _____ State: _____ Zip: _____ Phone: (_____) _____

☐ My check, made payable to **"La Clínica de La Raza"** is enclosed.

☐ Please charge my credit card: ☐ VISA ☐ MasterCard ☐ AmEx ☐ Discover

Name on card: _____ Card number: _____

Exp. Date: _____ Security code: _____ Signature: _____

☐ I want to contribute monthly through electronic fund transfer. Please call me at: (_____) _____

☐ My employer will match my contribution. Please call me at: (_____) _____

☐ This gift is (choose one) ○ in honor of ○ in memory of : _____

Kindly inform: _____

Address: _____

☐ I prefer to be listed as an anonymous donor

☐ Please send me information on Planned Giving

Unless otherwise designated, your contribution will be allocated where the need is the greatest. If you would rather donate to the Health Care Without Borders Campaign, please initial here: _____

Please mail your completed form with your enclosed check or designated credit card information to:

La Clínica de La Raza
Attention: Development Department
P.O. Box 17054
Oakland, CA 94601

For questions or assistance with telephone credit card transactions, contact Ketty Bacigalupi at 510-535-2933 or kbacigalupi@laclinica.org

On behalf of our 81,000 patients, Thank You!

Federal Tax ID#94-1744108