



DONATION FORM

Thank you for supporting our mission to Contribute to the health of the Community by improving health care Access, connecting people to Resources and promoting health Education.

Your generosity makes a difference!

Donor Information:

Name:

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Mailing Address:

Donation Amount:

☐

\$50

☐

\$100

☐

\$250

☐

\$500

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OTHER: \$ _____

Donation Method:

☐

Check enclosed (payable to CARE Clinic)

☐

Credit Card

Name on Card :

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Exp. Date :

CVV :

Please mail this form and your donation to:

CARE Clinic

906 College Ave

Red Wing, MN 55066

THANK YOU FOR YOUR DONATION!



651-388-1022



WWW.CARECLINICRW.COM