DONATION PROGRAM

The Mission of Hands of Grace Medical Clinic is to ensure that medically under-served and uninsured have access to quality health care.

Name(s) _____

Address_____

City _____ **State** _____ **Zip Code** _____

Telephone _____**Email** _____

☐ **Please add me to your mailing list.**

___ I would like to make a Recurring Gift as a: **___ Weekly Gift** **___ Bi-Weekly Gift** **___ Monthly Gift**

___ Quarterly Gift **___ Semi-Annual Gift** **___ Annual Gift**

Process my gift on the: **___1st** **___5th** **___10th** **___15th** **___20th** **___25th of the month**

Start Date: _____/_____/_____ ***(mm/dd/yyyy)***

OR

___ I would like to make a One-Time Gift

Donation Amount $ _____ ***All donations will be applied to General Fund.***

Comments: _____

___ Enclosed is a voided check for my recurring donation. Please transfer my gift from my checking account.

*****For One-Time Checking Account donations, please include a completed check with your donation form.***

OR

___ My credit card information is listed below for my donation. Please transfer my gift from my credit card.

Credit Card Number _____ **Expiration Date** _____ /_____

I understand my future donations will be transferred directly from my account as stipulated above. I understand that I may increase, decrease, or suspend my gift at any time through the online donation form at www.handsofgracemedical.com or by contacting Hands of Grace Medical Clinic, Inc. by phone or mail. All donations provided to Hands of Grace Medical Clinic, Inc. comply with U.S. Law.

Signature _____ **Date** _____
(Required)

Please make a copy of this form for your records or you can request a copy from
Hands of Grace Medical Clinic, Inc. • 1861 Watson Blvd • Warner Robins, GA 31093 • (478) 225-2811
www.handsofgracemedical.com