NCCHC Foundation Donation

Thank you for joining us to serve our community of correctional health care providers, facilities, patients, and public health.

About Your Donation

Donor Name / Recognized As:_____

Note: we will use this name to recognize this gift in our annual report listing and other donor recognition and stewardship.

Gift Amount:_____

☐I would like to donate an additional 3% to cover processing fees to ensure that all my support is used for programs.

Gift Designation:

☐Area of Greatest Need ☐Scholarship ☐ Education

Credit Card Information:

☐Visa ☐MasterCard ☐Amex ☐Discover

Card Number: _____

Card Expiration Date: _____ Card CVV: _____

Cardholder's Name (print name as it appears on credit card): _____

Billing Information

Address: _____

City: _____ State: _____ Zip code: _____

Telephone Number: (mobile / office / personal) _____

Email Address: _____

I authorize and acknowledge that all the above charges for the donation or other purchases, as identified above, will be posted to my credit card. I understand that upon receipt of this form, NCCHC will process the "Gift Amount" shortly thereafter.

Cardholder Signature: Date:

Please send completed form to (fax) 773-880-2424 or (email) info@ncchcfoundation.org.

Office use only

Account name: CC ORD#: Date of transaction: Initials: