CareFree Medical & Dental
Donor Giving Form

Name: _____

Address: _____

City, State, Zip: _____

Email: _____

Phone: _____

To be paid: _____ One time gift ____ Annually _____ Twice Annually ____ Monthly

Total Gift Amount: $_____

___ Enclosed

___ Date payment will start _____

Will send in increments of $_____

_____ Please charge my credit card in full:

CC# _____

Exp. Date: _____

_____ Please call me to discuss other opportunities for giving, such as appreciated securities, estate or planned giving or automatic bank withdrawals.

Please Use My Gift For:

_____ Area of Greatest Need - as identified by board of directors
_____ Endowment Fund
_____ Dental Clinic
_____ Medical Clinic

This Gift Is:

___ In honor of _____

___ In memory of _____

___ For the following occasion _____

___ Please notify the following person of this gift:

Name _____

Address _____

Gifts are tax deductible as allowed by law.

Send to:
CareFree Medical & Dental
5135 S. Pennsylvania
Lansing, MI 48910