Free Clinic
OF CENTRAL VIRGINIA

[✓] **YES, I want to help provide healthcare to vulnerable people in our community!**

Enclosed is my one-time contribution of:

☐$10 ☐$20 ☐$50 ☐$75 ☐$100 ☐$283* ☐Other Amount: $ _____

** $283 = cost to provide a full year of healthcare for one patient*

☐ Check enclosed (payable to the Free Clinic of Central Virginia)

☐ Please charge my credit card (please fill in credit card information below)

Please charge in full $ _____ OR Please charge monthly installments of $ _____

I want to be a Sustainer of the Free Clinic! Please charge my credit card each month:

☐ $10 ☐ $20 ☐ $50 ☐ $100 ☐ $ _____

Credit card will be charged this amount each month (renews annually).

☐ **Visa** ☐ **Mastercard**

_____ _____/_____ _____

Credit Card Number Expiration Date 3 Digit Code

Signature _____

Please help us by correcting or adding your contact information:

Name _____

Address _____ City, State, Zip _____

Home phone: _____ Cell phone: _____

Email address: _____

☐ I would like information about including the Free Clinic in my will.

☐ My company, _____, matches charitable gifts.

This gift is:

☐ in honor of or ☐ in memory of: _____

You may also make a secure donation online. Just click "Donate Now" at http://www.freeclinicva.org!

Thank you for your generosity.

Gifts are tax deductible as allowed by law.