DONATION FORM

Name ______________________________

Address ______________________________

City ______________ State ______________ ZIP ______________

Day Phone (   ) ______________ Evening Phone (   ) ______________

E-mail ______________________________

Would you like to receive our newsletter electronically? ❑ Yes ❑ No

I wish to support Crisis Clinic programs with my contribution of:

❑ $1,000 ❑ $500 ❑ $250 ❑ $100 ❑ $50 ❑ other $______________

PAYMENT METHOD

❑ My check is enclosed.

❑ I wish to charge my (please circle): Mastercard Visa

Credit Card Number: ______________ Expiration Date: ______________

Name as it appears on Card: ______________________________

❑ My donation is in memory of: ______________________________

❑ My donation is in honor of: ______________________________

❑ My employer will match my gift.

Name: ______________ Phone: ______________

PLEASE MAIL DONATIONS TO CRISIS CLINIC 1515 DEXTER AVE. N, SUITE 300, SEATTLE, WA 98109 OR FAX TO 206.461.8368