DONOR INFORMATION

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Other:

First Name: _____

Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____ Phone: _____

Contributions to Heart of Ohio Family Health are tax-deductible to the full extent of the law. For additional information on donating to Heart of Ohio Family Health, please call (614) 338-6818 To donate online, please visit heartofohiofamilyhealth.org.

HEART OF OHIO
FAMILY HEALTH

Heart of Ohio Family Health
5000 E. Main Street Columbus, Ohio 43213 (614)-235-5555

Yes! I want to help Heart of Ohio Family Health provide compassionate and high-quality health care to individuals and families who are ailing, struggling and may have nowhere else to turn. I designate my gift as follows:

DONATION LEVEL

☐ **$2,000** Pre-natal Screenings
(12 Visits During Pregnancy)

☐ **$1,000** Individual & Family Support
(For Individuals and Families in Need)

☐ **$500** Preventive Care Program
(6-Months of Screenings and Office Visits)

☐ **OTHER** _____

DONATION INFORMATION

☐ **One-time Donation** Amount of One-time Donation: _____

☐ **Recurring Donation** Amount of Recurring Donation: _____

☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

PAYMENT INFORMATION

☐ **My check, payable to Heart of Ohio Family Health, is enclosed.**

☐ **Please invoice me.**

Credit Card: ☐ **Master Card** ☐ **VISA** ☐ **American Express** ☐ **Discover**

Card Number: _____ Exp. Date: _____

Name on Card: _____

Signature: _____

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