



CREDIT CARD DONATION FORM

Nevada Health Centers, Inc.
Please send your completed form by fax (702) 307-5421 or mail to 4415 Spring Mountain Rd.
Suite 103, Las Vegas NV 89102
Attn: Shirley Hampton R.N.

Donor Name:			
Address			
Home Phone		Business Phone:	
E-mail:			

Type of Credit Card:		Gift Amount:	\$
Account Number:		Expiration Date:	
Name on Card:			
Billing Address (if deferent than above)			

If gift is in hour of an individual, please list name of honoree and indicate type of gift:

Name of Honoree: _____ Relation to you: _____

- | | |
|--------------------------------------|---|
| <input type="checkbox"/> In Memory | <input type="checkbox"/> Get Well Wishers |
| <input type="checkbox"/> Birthday | <input type="checkbox"/> Signature Event |
| <input type="checkbox"/> Anniversary | <input type="checkbox"/> Other: (Please list below) |
| <input type="checkbox"/> In Honor | _____ |

Please send notification of this gift to (optional):

Name:		Relation to Honoree:	
Address:			

I authorize Nevada Health Centers, Inc. to charge my Visa, Master Card or American Express for the above mentioned amount.

Signature Date

- Please check this box if you would like someone to contact you regarding this gift or to set-up a reoccurring gift.

Thank you for your generous support. Your donation is helping to support health access in our community