

Family Health Centers of Manatee Contribution and Pledge Form

FHCCM

To support FHCCM's mission to meet the growing needs of area citizens and businesses, I pledge my support.

Please complete this section or attach a business card.

Name: Mr. Mrs. Ms. Dr. : _____

Organization: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

E-mail: _____

Check all that apply:

- Former Patient Employee Current Patient MCRHS Board Member
 Corporate Partner Foundation Board Member Community Supporter Student Other:

Payment Options:

Enclosed is my one-time gift of \$ _____

I would like to contribute via credit card:

Credit Card/Bankcard Account Number: _____ Exp. Date: _____

Amount: \$ _____ American Express MasterCard Visa

Cardholder Signature: _____ Date: _____

Please make my credit card donation a monthly contribution.

Please deduct the first installment on the _____ of each month beginning. Please deduct the final installment on _____.

I will contribute/pledge my support online by visiting <http://www.fhccm.org/form.html> and completing the General donation section.

I pledge \$ _____ over a _____-year period.

My first pledge payment of \$ _____ is enclosed.

Please mail a pledge reminder to me: annually monthly quarterly semi-annually other _____

I would like to contribute stock. Please mail the applicable forms to me.

Gift Designation: Please use my gift where needed most.

Please use my gift to support:

- Pediatrics Women's Health Optometry/Vision Care Services
 Specialty Care (General Surgery, Podiatry, Perinatology) Buildings/Facilities Medical equipment
 Employee and Medical Staff Recruitment Community Outreach/Events Educational resource Other:

The **Family Health Care Centers of Manatee** is tax-exempt under IRS Code 501(c)(3) Foundation that is committed to its mission to in supporting Manatee County Rural Health Service Area in expanding access to affordable, quality health care for underserved individuals and communities and to promote fundamental improvement in the health status of the people in the Manatee County Rural Health Service Area.

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Matching Gift: Yes, my company will match my gift. Please contact me for the appropriate documentation for the pledged gift.

Memory/Honor: My gift is in memory of: _____

My gift is in honor of: _____

Please mail an acknowledgement to: (*name*) _____ (*address*)

Public Recognition: May the Family Health Care Centers publicly acknowledge this commitment? (Please note: By checking "yes," you are authorizing the Foundation to list you as a donor in Foundation publications, such as the Foundation annual report.) Yes No

Signature Acknowledgement: My signature acknowledges my pledge:

Signature Date

**Please return to
Family Health Care Centers of Manatee Foundation
P.O. Box 499
Parrish, Florida 34219**

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