



YOUR HEALTH | YOUR CLINIC | YOUR NEIGHBORHOOD

NEIGHBORHOOD HEALTH CENTER DONATION FORM

I would like to make a donation to help provide support for programs and patient services at Neighborhood Health Center whose mission is Building healthy communities – one neighbor at a time – through patient-centered health care, regardless of income or current state of wellness.

Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell Phone: _____

Email: _____

Please use my gift: Where most needed Patient Services Other

PAYMENT INFORMATION: Check (payable to Neighborhood Health Center)

Credit/Debit Card Visa MasterCard Discover American Express

Card Number: _____ Expires: _____

CVC / CIN*: _____ Signature: _____

CVC/CIN is a 3-digit code on credit cards that can be found on the back of the card on or to the right of the signature strip.

Make this a monthly recurring donation. Charge my credit card \$ _____ and then \$ _____ a month until (date) _____ (minimum \$10 a month).

NAME AS YOU WOULD LIKE IT TO APPEAR FOR RECOGNITION (select one):

As Listed Above: Anonymous Other: _____

In honor of: _____ In the name of: _____

If your donation is 'in honor of' or 'in the name of' we will send a letter acknowledging your gift to:

Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell Phone: _____

Email: _____

My company/employer makes matching gifts. I have enclosed my company's matching gift information form.

Company / employer: _____

**Please return this form along with your check or credit card information to:
Neighborhood Health Center, 6420 SW Macadam Ave., Suite 300, Portland, OR 97239**

Questions? Contact Penny L Moore, Community Relations Manager at 503.941.3054 or moorep@NHCOregon.org