



Since  
1995

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## DONATION FORM

Please accept my tax-deductible gift of:

\$1,000    \$500    \$250    \$100    \$50    Other \$\_\_\_\_\_

My check payable to **Viola Startzman Free Clinic** is enclosed.

I would like to make a gift of \$\_\_\_\_\_ according to the payment schedule outlined below:

\$\_\_\_\_\_ per **month** beginning on \_\_\_\_\_  
(date)

\$\_\_\_\_\_ per **quarter** beginning on \_\_\_\_\_  
(date)

\$\_\_\_\_\_ per **year** beginning on \_\_\_\_\_  
(date)

Please check one:

- I authorize VSFC to automatically withdraw donations from my bank account. ***I have attached a voided check or savings deposit slip.*** This authority will remain in effect until I give reasonable notification to terminate the authorization.
- I would prefer for VSFC to mail a reminder to me on a regular basis.

Name \_\_\_\_\_  
*as you would like it to appear in clinic materials*

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Employer \_\_\_\_\_

- I have included/want to include the Viola Startzman Free Clinic in my estate plan.  
Please contact me at \_\_\_\_\_.
- My gift is in memory or honor of \_\_\_\_\_, if applicable.
- I would like my gift to remain anonymous.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Please mail to: Viola Startzman Free Clinic, 1874 Cleveland Road, Wooster OH 44691**

**Thank You!**