Annual Giving

I/We support the mission of The Free Clinic of Doylestown. My gift of $ ______________________ is enclosed.

☐ ***OR*** I would like to pledge $ ______________ to be payable by (date) ______________________

Please designate this gift for: ☐ Area of greatest need: ☐ Operating costs ☐ Holiday program for patients ☐ Other: __________

Donor Name(s): ____

Donors will be recognized in the following categories:

☐ Patrons Circle ($10,000 and above)

☐ Benefactors Circle ($5,000 to $9,999)

☐ Presidents Circle ($1,000 to $4,999)

☐ Circle of Caring ($500-$999)

☐ Sponsors ($250 to $499)

☐ Friends ($100 to $249)

☐ Honor Roll of Donors (up to $99)

Credit Card: ☐ Master Card ☐ Visa ☐ American Express Card#: ______________________________

Exp. Date: __________ Signature: ______________________________________

Please print and fill out the form. Mail the form and your check to:

The Free Clinic of Doylestown

Dignity, Respect & A Sense of Community

595 West State Street • Doylestown, PA 18901