



---

**I wish to make a donation to the Crossing Healthcare**

(All donations are tax deductible)

---

**I wish to make a monetary donation of:**

**\$25      \$50      \$100      \$500      \$1,000      Other \$ \_\_\_\_\_**

---

**Please fill out the following information:**

Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Zip Code \_\_\_\_\_

Amount donated \$ \_\_\_\_\_

**If you wish to make a donation by credit/debit card please provide the following information:**

**Visa            Mastercard**

No. \_\_\_\_\_

Exp. Date \_\_\_\_\_

Name shown on card \_\_\_\_\_

Signature \_\_\_\_\_

\*Checks made payable to Crossing Healthcare

---

**Thank you!**