

# Triad Health Project Donation Mail Form

*Please print and mail this form to*  
TRIAD HEALTH PROJECT • PO BOX 5716 • GREENSBORO, NC 27435

## **DONOR INFORMATION (Please print)**

Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

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

Daytime Telephone \_\_\_\_\_

(Optional) In Honor Of: \_\_\_\_\_

(Optional) In Memory Of: \_\_\_\_\_

## **ACKNOWLEDGEMENT CARD INFORMATION (Please print)**

*We will send a card if the donation is in honor or memory to:*

Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

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

## **PAYMENT OPTIONS**

**I wish to donate: \$** \_\_\_\_\_

I am enclosing a check. (Make checks payable to *Triad Health Project*)

I prefer to pay by credit card.

MasterCard

Visa

American Express

Credit Card Number \_\_\_\_\_

Name as it appears on the credit card \_\_\_\_\_

Credit Card Expiration Date (month/year) \_\_\_\_\_

Please sign here indicating authorization to charge your credit card for this donation:

\_\_\_\_\_

*Thank you very much for your donation to Triad Health Project.*