



Family Tree Clinic

Because your sexual health matters

Contribution Form

Donor Information (Please print or type)

Name	
Billing address	
City	
State	
Zip Code	
Telephone (home)	
Telephone (business)	
Email	

Contribution Information

I (we) pledge a total of \$ _____ to be paid: ____ now ____ yearly.

I (we) plan to make this contribution in the form of: __ cash __ check __ credit card __ other.

Credit Card type (VISA/MC)	
Credit Card number	
Expiration Date	
Authorized signature	

Acknowledgement Information

Please use the following name(s) in all acknowledgements:

___ I (we) wish to have our gift remain anonymous.

___ I (we) wish to give this gift in honor or memory of _____.

Signature(s)
Date

Please make checks, or other gifts payable to:

Family Tree Clinic 1619 Dayton Avenue, Suite 205 St. Paul MN 55104