



# CREDIT CARD AUTHORIZATION FORM

## CONTACT AND DONATION INFORMATION:

FULL NAME(S): \_\_\_\_\_

PHONE: \_\_\_\_\_ EMAIL: \_\_\_\_\_

I / we would like to donate \$ \_\_\_\_\_

\_\_\_\_\_ Monthly on the \_\_\_\_\_ 1<sup>st</sup> or \_\_\_\_\_ 15<sup>th</sup> of each month.

\_\_\_\_\_ Quarterly on the 1<sup>st</sup> of January, April, July & October.

\_\_\_\_\_ One time donation.

**Donation Designation:** Please indicate below how you would like your donation used. You may also donate to multiple designations by indicating a dollar amount in the spaces. By choosing general expenses we will determine where your donation can have the greatest impact.

General Expenses \_\_\_\_\_ Missionary Support: Catherine Wolf, M.D. \_\_\_\_\_

Cherlie Severe, R.N. \_\_\_\_\_

## CREDIT CARD INFORMATION:

Card type (circle):                      Mastercard      Visa      American Express      Discover

Card#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Expiration date: \_\_\_\_\_ / \_\_\_\_\_

Name as it appears on card: \_\_\_\_\_

Billing address: \_\_\_\_\_

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

## AUTHORIZATION:

I authorize Friends for Health in Haiti to charge my credit card as indicated above. Authorization for monthly and quarterly donations will remain in effect until I notify Friends for Health in Haiti in writing that I wish to make a change to my donation or to terminate this agreement.

Date: \_\_\_\_\_ Signature of Cardholder: \_\_\_\_\_

You will receive a letter confirming this arrangement as soon as it is processed. You will receive a year-end summary of your donations for tax purposes. We would be happy to send an acknowledgement for each donation as it is processed.

Please indicate your preference: \_\_\_\_\_ Year-end receipt only  
\_\_\_\_\_ Acknowledge each donation by \_\_\_\_\_ mail \_\_\_\_\_ email

**Mail completed form to:**  
Friends for Health in Haiti  
P.O. Box 122  
Pewaukee, WI 53072

**or fax:**  
866-491-5406

**THANK YOU FOR YOUR SUPPORT!**