CALL FOR HEALTH

GIVE THE GIFT OF HEALTH
Donate by Mail Form

Name: ______________________________

Address: ______________________________

City, State, Zip code: ______________________________

E-mail: ______________________________

- [ ] **$2,000** - [ ] **$1,000** - [ ] **$500** - [ ] **$250** - [ ] **$100** - [ ] **Other: $** __________

Credit Card Payment type: (please circle one)

VISA **MasterCard** **American Express** **Discover**

Credit Card Number: ______________ **Expiration Date:** __________

Signature: ______________________________

- [ ] **Donation in Honor of:** ______________________________
- [ ] **Donation in Memory of:** ______________________________
- [ ] **Check Enclosed**
- [ ] **I would like additional information sent to me about the Call for Health Program**

THANK YOU FOR YOUR DONATION!

Mail to:
National Center for Farmworker Health, Inc.
1770 FM 967, Buda, TX 78610
(800) 531-5120 (phone); (512) 312-2600 (fax); www.ncfh.org
Tax ID: 74-1826899