

The Hoosick Falls Health Center

DONATION FORM

Contact Name: _____

Address: _____

City / State / Zip: _____

Phone Number: _____

Please fill out completely so we can Thank You appropriately.

\$25 \$50 \$100 Other _____

Please attach check made payable to:

The Hoosick Falls Health Center Foundation, Inc.

OR

Credit Card Type: _____

Credit Card #: _____

Name on Card: _____

Security Code: _____ Exp. Date: _____

Return to: Hoosick Falls Health Center, Inc.
 Kathy Fleming, Administrative Assistant
 P.O. Box 100
 Hoosick Falls, New York 12090