DONATION FORM

DATE _____ /_____ /_____

CONTACT/DONOR INFORMATION

Name(s): _____

Business (if applicable): _____ ☐ *Business is the donor*

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Email: _____ Phone: _____

☐ My donation is for a specific Compass Health program/event: _____

IN-KIND CONTRIBUTION

Item & Description (quantity, size, color, number of persons, days/nights, any restrictions, etc.): _____

_____

_____

_____

Estimated Dollar Value: $ _____

FINANCIAL CONTRIBUTION

☐ $1,000 ☐ $500 ☐ $250 ☐ $100 ☐ $50 ☐ $25 ☐ $_____

BILLING INFORMATION

☐ Check *(Please make payable to Compass Health)* Check #:_____

☐ Visa ☐ Mastercard ☐ Discover

Card #: _____ Billing Address: _____

Exp. Date: _____ / _____ CSC: _____ *If different than contact address* _____

Card Holder's Signature: _____

Donor's Signature: _____

Send completed forms to Compass Health | Development Department | 4526 Federal Avenue| M/S #49 | Everett, WA 98203

Contact us at development@compassh.org

By submitting this form you are signing up to be on Compass Health's mailing list and will receive information about upcoming campaigns, events, and other Compass Health news. If you do not want to be on this list please check the box: ☐