

# Credit Card Authorization Form

Please return the completed form via fax at (952) 844-9842 or via mail to Community Health Charities Minnesota (CHCM) at 2626 East 82<sup>nd</sup> Street Suite 225, Bloomington, MN 55425. The form can also be e-mailed to Molly Gravholt at [mgravholt@healthcharities.org](mailto:mgravholt@healthcharities.org).

## Donation Information:

For: \_\_\_\_\_

Amount I would like to donate: \$ \_\_\_\_\_

I would like my gift acknowledged (circle one):      yes      no

Please indicate how you would like your gift distributed:

- To all 33 local member charities
- As operating support for CHCM
- Designated to the following Community Health Charities member(s) or ANY tax-exempt 501(c) 3 nonprofit organization. Please provide address and phone number for non-members organizations:

\_\_\_\_\_

\_\_\_\_\_

## Tribute:

This gift is in honor or memory of someone (circle one):      yes      no

If yes, and you would like special tribute card sent:

Honoree name: \_\_\_\_\_

Honoree address: \_\_\_\_\_

## Contact Information:

Last name: \_\_\_\_\_ First name: \_\_\_\_\_

Address: \_\_\_\_\_

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

Telephone: \_\_\_\_\_ E-mail: \_\_\_\_\_

## Credit Card Information:

Card type (circle one):      Visa      MasterCard      AmEx      Discover

Card number: \_\_\_\_\_ Expiration date (mm/yy): \_\_\_\_\_

Name (exactly as it appears on the card): \_\_\_\_\_

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

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

## Authorization:

I authorize CHCM to charge my credit card for the amount noted above.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_