care resource

Your Community's Source for Healthcare

DONATION FORM

Thank you for supporting Care Resource! Your contribution makes a direct impact in our ability to continually expand our services and provide quality healthcare for all who need it.

Donation Amount

Select the amount of your donation below:

__ $25
__ $50
__ $100
__ $500
__ Other
(Specify Amount: $_________)

Designation

Specify where you would like your donation to go

__ Where it is needed most
__ Capital Fund
__ Emergency Assistance Fund
__ Food for Life Network Food Pantry
__ Other (Specify Designation: ____)

Tribute Gift

This gift is in honor, memory, or support of someone.

__ In honor of
__ In memory of
__ Person's name (____)
__ Please notify the following person of my gift
__ Specify name and address or email:
(____)

Billing Address

Name: ____________________ Email: ____________________
Phone: ____________________ Country: ____________________
Address: ____
City: ____________________ Zip: ____________________
State: ____________________

Payment Details

Cardholder name: ____
Cardholder number: ____
Expiration date: __________ Card security code: __________
Cardholder signature____

Company Matching Gifts

__ This gift can be matched Matching Company Name: ____________________

Please fill this form and send it with your donation to:

Care Resource Community Health Centers
c/o Development
3510 Biscayne Blvd, Miami, FL 33137

MIAMI-DADE COUNTY

Midtown Miami
3510 Biscayne Blvd.
Miami, FL 33137
T: 305.576.1234
F: 305.571.2020

Little Havana
1901 SW 1st St.
3rd Floor
Miami, FL 33135
T: 305.203.5230
F: 305.203.5231

Miami Beach
1680 Michigan Ave.
Suite 912
Miami Beach, FL 33139
T: 305.534.0503
F: 305.538.4090

BROWARD COUNTY

Fort Lauderdale
871 W Oakland Park Blvd.
Oakland Park, FL 33311
T: 954.567.7141
F: 954.565.5624

Oakland Park
3160 Powerline Road
Oakland Park, FL 33309

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