



ASIAN HEALTH SERVICES

HEALTH CARE FOR ALL. ADVOCACY FOR THE UNDERSERVED.

PAYMENT INFORMATION

- My check made payable to **Asian Health Services** is enclosed
- Please make a one-time charge of \$_____ to my credit card.
- I would like to make a monthly contribution of \$ _____ beginning on _____ and ending on _____

VISA Mastercard Discover American Express

Account # _____
 Security Code / CCV _____
 Expiration Date _____ / _____
 Signature _____

- I have applied for a matching gift from my employer: _____
Company Name

I'd like my donation to go to: General fund or
 Program Designation: _____
i.e. Mobile & Telehealth Campaign / Dental / Youth / etc.



- I wish to remain anonymous

This gift is in honor / memory of _____

I'd like the following person to be notified of my gift:

Name: _____

Mailing address: _____



COMMUNICATION PREFERENCES

Please indicate how you'd like to keep updated with AHS in the future

- Telephone: (_____) _____ - _____
- Email: _____
- Mail I have a new address! It is: _____

Please mail this form to:
 Asian Health Services
 Development Department
 101 8th Street, Suite 100, Oakland, CA 94607

THANK YOU FOR YOUR SUPPORT