Camillus Health Concern
dba GOOD SHEPHERD HEALTH CENTER

Please mail this form and your check to:
Camillus Health Concern, Inc.
336 NW 5th Street, Miami, FL 33128-1616

PLEASE PRINT ALL INFORMATION CLEARLY.

Date: _____

Enclosed is my check in the amount of $ _____ payable to Camillus Health Concern.

Name: _____

Address:_____Telephone: _____

City:_____State:_____Zip_____

PLEASE CHOOSE THE TYPE OF DONATION YOU ARE MAKING:

☐ **General Donation**

☐ **Gift in memory of:** _____

Name of deceased

Please send an acknowledgement card to:

Name: _____

Address: _____

City:_____State:_____Zip: _____

Tell us how you would like to have the card signed: _____

Name of person

☐ **Gift in honor of:** _____

Name of person

Please send an acknowledgement card to:

Name: _____

Address: _____

City:_____State:_____Zip: _____

Tell us how you would like to have the card signed: _____

Name of person

Camillus Health Concern thanks you for your support of our mission.

Your contribution is tax-deductible. 100% of all contributions are received by Camillus Health Concern.