OTMDC | Olde Towne Medical & Dental Center

Please print and fill out the form and mail to:
5249 Olde Towne Rd
Williamsburg, VA 23188

Apply To Our Everyday Giving Campaign: _____ or
Apply To A Specific Campaign/Fundraiser: _____

Donate by check:

THANK YOU FOR INVESTING IN OUR PATIENTS' HEALTH!

Amount Enclosed ( )$500 ( )$250 ( )$100 ( )$50 ( )$25 ( )$_____ Other

Donor Name ( )Mr. ( )Mrs. ( )Mr. & Mrs. ( )Ms. ( )Dr. _____

Spouse/Partner's Name (Joint gift only) _____

Address _____

City, State, Zip _____

Telephone ( ) _____ Email _____

This gift is is honor/memory of _____

Please notify _____
Name Address

☐ **ANONYMITY REQUESTED**
☐ **MATCHING DONOR INFORMATION ENCLOSED**

Donate by credit Card:

PLEASE CHARGE MY CREDIT CARD: ☐ VISA ☐ MASTERCARD ☐ DISC. ☐ AM. EXP.
☐ ONE TIME GIFT OF: ☐$25 ☐$50 ☐$75 ☐$100 ☐Other $ _____
☐ MONTHLY GIFT OF: ☐$25 ☐$50 ☐$75 ☐$100 ☐Other $ _____
☐ I authorize OTMDC to charge my card monthly until (end date) ___/___/____.
☐ I authorize OTMDC to charge my card monthly until I notify them in writing to stop.

Name on Card: _____

Card Number: _____

Expiration Date: _____Security Code (3/4-digit) _____

Billing Address: _____

_____

Signature: _____ Phone Number: _____

( ) Please send me information on gifts by securities.

Olde Towne Medical & Dental Center Patients Thank You For Your Support