OFFICIAL DONATION RECEIPT

[Medical Clinic Name]
[Clinic Address Line 1]
[City, State, Zip Code]
[Tax ID / EIN Number]

Receipt #: _____

Date of Issue: _____

Donor Information
Name: _____
Address: _____
Phone: _____
Email: _____

Donated Equipment Description

Item Description (Make/Model/Year)	Qty	Condition	Appraised Fair Market Value
			$
			$
		Total Eligible Value:	**$**

Date Equipment Received: _____

Location of Donation: _____

Note: No goods or services were provided by the clinic in return for the contribution indicated above. Please retain this receipt for your tax records. Appraisal of non-cash equipment is the responsibility of the donor for tax deduction purposes.

Authorized Clinic Representative Signature
Printed Name & Title