[Clinic Name]

[Street Address]
[City, State, Zip]
[Phone Number]
[Tax ID / EIN]

ASSET DONATION RECEIPT

Receipt #: _____
Date: _____

DONOR INFORMATION

[Donor Name / Organization]
[Address]
[City, State, Zip]
[Email/Phone]

DONATION DETAILS

Donation Type: Medical Equipment / Asset
Condition: [ ] New [ ] Used [ ] Refurbished

Description of Asset (Make, Model, Serial #)	Qty	Estimated Fair Market Value	Total Value

Total Appraised Value: $ _____

[Clinic Name] is a 501(c)(3) non-profit organization. No goods or services were provided in exchange for this contribution. Please retain this receipt for your tax records.

Authorized Clinic Representative Signature

Donor Signature