

MEDICAL EMERGENCY RELIEF FUND

Organization Address Line 1

City, State, Zip

Tax ID / EIN: 00-0000000

INVOICE NUMBER

#0000

DATE

Month DD, YYYY

DONOR INFORMATION

Name / Company

Address

Email / Phone

PATIENT/CASE REFERENCE (OPTIONAL)

Case ID / Name

Relief Category

Description of Contribution	Amount
General Medical Emergency Fund Donation	\$0.00
Designated Relief Support: _____	\$0.00

Subtotal: \$0.00

Processing Fees: \$0.00

Total Donation: \$0.00

PAYMENT METHOD

Check / Wire Transfer / Credit Card / Cash

This contribution is tax-deductible to the extent allowed by law.

No goods or services were provided in exchange for this contribution.

Thank you for your life-saving support.