

Donation Invoice

Chronic Disease Management Initiative

INVOICE # [0000]
DATE [MM/DD/YYYY]

ORGANIZATION INFO [Organization Name]

[Street Address]

[City, State, Zip]

[Tax ID / EIN Number]

DONOR INFO [Donor Name / Company]

[Donor Address]

[Email Address]

Description of Contribution	Program/Focus Area	Amount
[General Donation / Specific Grant]	[e.g., Diabetes Care / Heart Health]	\$0.00
[Equipment or Supply Donation]	[Patient Resource Center]	\$0.00
Total Contribution:		\$0.00

PAYMENT METHOD Check Wire Transfer Credit Card In-Kind

NOTES / TERMS

No goods or services were provided in exchange for this contribution. This donation is tax-deductible to the extent allowed by law.

Thank you for supporting chronic disease management and improving patient outcomes.