# Community Health Program

123 Wellness Way, Medical District
City, State, ZIP
contact@communityhealth.org

## DONATION INVOICE

Invoice #: _____
Date: _____

### DONOR INFORMATION

**Name:** _____
**Address:** _____
**Email:** _____

### PROGRAM IMPACT AREA

General Fund
Vaccination Outreach
Nutritional Support
Maternal Care

| Description | Tax Deductible | Amount |
|---|---|---|
| Charitable Donation: _____ | [ Yes / No ] | $ _____ |
| Specific Grant Contribution: _____ | [ Yes / No ] | $ _____ |
| Other Support: _____ | [ Yes / No ] | $ _____ |

Subtotal: $ _____
Processing Fees: $ _____
TOTAL DONATION: $ _____

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**Tax Information:** Community Health Program is a registered 501(c)(3) non-profit organization. Your contribution is tax-deductible to the extent allowed by law. No goods or services were provided in exchange for this contribution.

*Thank you for supporting community wellness.*