

EMERGENCY MEDICAL RELIEF

[Organization Address Line 1]
[City, State, Zip Code]
Tax ID: [00-0000000]

DONATION RECEIPT

Date: [MM/DD/YYYY]
Receipt #: [00000]

Donor Information:

[Donor Name]
[Donor Address]
[Email/Phone]

Relief Program:

[Program Name/Disaster Area]
Priority: [Emergency/Urgent]

Description of Donation	Type	Amount/Value
[Medical Supplies / Cash Contribution / Service]	[Monetary/In-Kind]	\$0.00
[Additional Item/Service Description]	[Monetary/In-Kind]	\$0.00

Total Contribution: \$0.00

No goods or services were provided in exchange for this contribution. Emergency Medical Relief is a registered 501(c)(3) non-profit organization. Your donation is tax-deductible to the extent allowed by law.

Authorized Signature