

# MATERNAL HEALTH PROGRAM

123 Wellness Way, Suite 100  
City, State, Zip Code  
contact@maternalhealth.org

## DONATION RECEIPT

Receipt #: \_\_\_\_\_  
Date: \_\_\_\_\_

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### DONOR INFORMATION

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Email: \_\_\_\_\_

### PAYMENT METHOD

Credit Card /  Check /  Bank Transfer  
Reference No: \_\_\_\_\_

| Description of Contribution / Program Fund | Amount  |
|--|---------|
| Prenatal Care & Nutrition Support          | \$ 0.00 |
| Midwifery & Skilled Birth Attendance       | \$ 0.00 |
| Postnatal Support & Neonatal Care          | \$ 0.00 |

| Description of Contribution / Program Fund | Amount  |
|--|---------|
| Emergency Obstetric Fund                   | \$ 0.00 |

Subtotal: \$ 0.00

**TOTAL DONATION: \$ 0.00**

The Maternal Health Program is a registered 501(c)(3) non-profit organization.

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

Thank you for supporting safe motherhood and healthy beginnings.