PUBLIC HEALTH INITIATIVE

Organization Address Line 1
City, State, Zip Code
Tax ID: ________________

DONATION RECEIPT

Date: ________________
Receipt #: ______________

Donor Information:
Name: __________________________
Address: ________________________
Email: _________________________
Payment Method:
[ ] Check [ ] Credit Card
[ ] Wire [ ] Other: __________

Description of Contribution	Program/Fund Site	Amount
Charitable Contribution	_____________________________	$ ____________
Non-Monetary (In-Kind) Gift	_____________________________	$ ____________

Total Tax-Deductible Amount: $ ________________

Official Statement: No goods or services were provided in exchange for this contribution. This organization is a qualified 501(c)(3) non-profit organization. Please keep this receipt for your personal tax records.

Authorized Signature: ___________________________________ Date: _______________