

[Rural Health Clinic Name]

[Street Address]
[City, State, Zip Code]
[Phone Number]

DONATION RECEIPT

Date: [Date]
Receipt #: [00000]

DONOR INFORMATION

[Donor Name]
[Donor Address]
[City, State, Zip]
[Email/Phone]

TAX IDENTIFICATION

EIN/Tax ID: [00-0000000]
Status: 501(c)(3) Non-Profit

Description of Donation	Type	Value/Amount
[Description of monetary gift or items]	[Cash/In-Kind]	\$0.00

Total Contribution: **\$0.00**

Thank you for your generous support of rural healthcare.

No goods or services were provided in exchange for this contribution. Please retain this receipt for your tax records.

Authorized Signature