



FirstChoice Clinic – Friends for Life Donor Commitment Form

Thank you for enrolling in an automatic giving program to benefit the clients served by FirstChoice Clinic. Your long-term promise permits the continuation of valuable services in our community. Please return the form to FirstChoice Clinic, 1351 Page Dr., Suite 205, Fargo, ND 58103.

My contact information:

Name(s): _____ Phone: _____
Address: _____ Cell: _____
City/State/Zip _____ Email: _____

I would like to make a monthly contribution in the amount of: (Minimum \$10/month)

- \$10 per month \$35 per month \$75 per month Other \$ _____ per month
 \$25 per month \$50 per month \$100 per month

I would like to use the following method for payment: (Choose one method)

- Please set up an automatic payment through my checking or savings account **(complete section A)**
 Please set up an automatic payment through my credit card **(complete section B)**

Also

- My employer offers a MATCHING GIFT program **(complete section C)**

ELECTRONIC FUND TRANSFER

A. Information for automatic withdrawal from my checking or savings account:

- Checking Savings

I want my bank to transfer monthly donations to FirstChoice Clinic. My authorization to charge my account shall be the same as if I had personally signed a check to FirstChoice Clinic. This authorization shall remain in effect until I notify FirstChoice or my bank in writing that I wish to end this agreement and FirstChoice or my bank has had a reasonable time to act on it. A receipt will be sent monthly.

Please enclose a voided check for verification and bank information. All information will remain confidential

Amount of monthly gift \$ _____ Date to be debited each month: 1st of the month
 19th of the month

Signature: _____ Date: _____

Print Name: _____

CREDIT CARD

B. Information for an automatic payment through my credit card:

- Please Charge my monthly contribution to my Credit Card

Visa MasterCard Card Number: _____

Amount of monthly gift \$ _____ Exp. Date: _____

Date to be debited each month: 1st of the month 10th of the month

This payment authorization is valid and is to remain in effect unless I notify FirstChoice Clinic of its cancellation by sending written notice two weeks prior to the cancellation date.

Signature: _____ Date: _____

Print Name: _____

CORPORATE MATCH

C. Information on employer matching gifts:

My employer will match my tax-deductible gift to FirstChoice Clinic.

Employer Name: _____

Please enclose your corporate match form

Rather than a monthly commitment, I would like to make a one-time gift in the amount of:

\$35 \$50 \$75 \$100 \$250 \$500 Other \$ _____

Please check all that apply:

- I would like additional information pertaining to leaving a gift to FirstChoice Clinic in my will.
- I would like additional information pertaining to making a stock contribution.
- I would like information about volunteer opportunities at FirstChoice Clinic.
- I would like information on FirstChoice Clinic's Annual Fundraisers.
- I would like to donate an In-Kind Gift to your baby boutique.

FirstChoice Clinic is a non-profit, 501(c)(3) corporation. Contributions to FirstChoice Clinic are tax-deductible as provided by law. Please return all contributions and this form to the address below. FirstChoice Clinic does Not rent, sell, or trade its donor list and will Not share your address with any other organization.

THANK YOU!



FirstChoice Clinic is a faith based nonprofit clinic providing education and health services to empower individuals to make life-affirming choices.

**FirstChoice Clinic
1351 Page Dr, Suite 205
Fargo ND 58103**

**701.237.5902 (p)
701.237.0363 (f)**

**e-mail: info@firstchoiceclinic.com
www.teamfirstchoiceclinic.com**