

DDC Clinic for Special Needs Children

Your Donation is tax deductible to the extent permitted by law under Section 501(c) (3) of the Internal Revenue Code.

Please return this form to:

DDC Clinic
P.O. Box 845
Middlefield, OH 44062

Donor Information:

Name _____

Address _____

City _____ State _____ Zip Code _____

Country _____

Daytime Phone () _____ Evening Phone () _____

E-mail Address _____

- Yes, I would like to be added to your mailing list.
- Yes, I would like to be added to your e-mail list.
- I would like to request a speaker for a presentation to a community group / organization.
- I wish to volunteer to assist in the growth of the DDC Clinic.

Gift Information:

Enclosed is my gift of \$ _____ (Please make check payable to DDC Clinic)

Please charge my Credit Card for \$ _____ MasterCard® Visa®

Credit Card Number _____

Expiration Date _____

Name on Card _____

Signature _____

Please bill my Credit Card: One Time Only Monthly Quarterly Annually

My gift will be matched by my company:

Company Name _____

Contact Name _____ Contact Phone () _____

Please have a planning officer contact me about stock donations and other planned giving options.

Please make the donation in memory / honor of:

Name _____

Please acknowledge my gift to:

Name _____

Address _____

City _____ State _____ Zip Code _____