



MAIL / FAX CONTRIBUTION FORM

DONOR INFORMATION: (as to appear for donor recognition) Please keep my gift anonymous:

Donor(s) Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Email: _____

GIFT INFORMATION:

I have enclosed a check made out to Vision Health International in the amount of \$_____

Please charge my credit card in the amount of \$_____

AMEX Discover MasterCard VISA

Name on Card: _____ Billing Zip Code: _____

Card Number: _____ Expiration: _____

MEMORIAL & TRIBUTE INFORMATION (OPTIONAL):

If you would like to make your gift in honor of someone special, please indicate below:

In Memory of _____ (name)

In Honor of _____ (name)

Occasion:

Anniversary Birthday Graduation

Other _____

I would like a notification card without the gift amount mailed to:

Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Please mail or fax this form to:

Vision Health International • PO Box 597 • Grand Junction, CO 81502

Fax: (707) 224-9420

For more information please contact Nicole Fedoravicius, Chief Operating Officer

Phone: (877) 689-2981

Thank You for Your Gift to Restore Sight

Vision Health International's Federal Tax Identification Number is: 94-3108791