



## Gift Form

I would like to make a contribution to Volunteers in medicine to support the health and wellness needs of the medically uninsured or underserved population living or working in Cape May County.

Enclosed is a check payable to Volunteers in Medicine in the amount of \$\_\_\_\_\_.

Please bill my: Visa €Master Card €

Account No. \_\_\_\_\_

Exp. Date \_\_\_\_\_ CCV Code: \_\_\_\_\_

Signature \_\_\_\_\_

Name: \_\_\_\_\_

Company: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

€ This gift is in honor of \_\_\_\_\_

€ This gift is in memory of \_\_\_\_\_

€ I would like my gift to remain anonymous

Mailing Address: 423 North Route 9, Cape May Court House, NJ 08210

*Volunteers in Medicine of Cape May County is a charitable organization within the meaning of section 501 ©(3) of the Internal Revenue Code. Donations are tax deductible as allowed by law.*