

**Give the gift of healthcare
to those underinsured
or without health insurance.**

Gift Instructions

***Please select one:**

- Please use this contribution to advance *Portsmouth Community Health Center, Inc.'s* patient care programs.
- Please use this contribution towards *Park Place Medical Center*.
- I want my gift to specifically go to: (Name of recipient)_____.
- Please use this gift for dental services at *Healthy Smiles Dental Center*.

Credit Card Information:

***Required information**

- *Amount: \$_____
- *Credit Card: Visa ___ MasterCard___
American Express___
- *Cardholder Name_____ (Exactly as it appears on card.)
- *Credit Card Number: _____
- *Expiration date: _____

Contact Information: Please indicate where the receipt should be mailed, and to whom it should be addressed:

- *First name: _____
- *Last name: _____
- *Address: _____
- *Phone: _____
- *Email: _____

Thank you for your contribution!

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