DONATION FORM

Kitsap County Medical Society

PO BOX 490
Silverdale, WA 98383
O: 360.689.2928
F: 360.204.5709

DONOR (One donor name per form, please.)

(Name as it should appear in print materials including blank boxes between words, etc. 35 total characters/boxes maximum)

DONOR CONTACT INFORMATION

Last Name	First Name	Middle Initial	Title (Mr., Ms., Mrs., etc)
Mailing Address			
City		State	Zip

Home/Work	Cell	Fax	Email

(We will contact you if clarity is needed on donor listing, item, restrictions, etc.)

ITEM INFORMATION

Item name & Description ☐ Check if restrictions apply (and list below or continue on back)	Value: $ _____. ____
Is there more than one donor for this item? ☐ No ☐ Yes (if so, please fill out one form per donor and ensure item name is identical.)	
Item is (please check one): ☐ To be delivered or mailed ☐ To be picked up ☐ Included with form	

FINANCIAL CONTRIBUTION

If making a financial contribution, please enclose a check or complete the credit card information below:

Amount: $ _____.___	
☐ VISA ☐ MASTERCARD Card No.:	Exp Date: _____/_____/20____
Name on Card:	Signature:

SIGNATURE

I agree to donate the above listed item(s) to the Kitsap County Medical Society Foundation. Your donation is tax deductible under the KCMSF Tax ID No. 91-2089484. Please consult with your financial advisor as to the tax deductible benefits of your donation.

Signature	Date

FOR PROCUREMENT/OFFICE USE ONLY

Procured by	Date Received
	Rcvd: _____ Item Number: _____

Return Form to:

Kitsap County Medical Society

PO BOX 490 ▪ Silverdale, WA 98383 ▪ Ph: (360) 689-2928 ▪ Fax: (360) 204-5709

kcmsmed@gmail.com ~ www.kcmedical.org