



I Want to Make a Healthy Difference!

Please fill out this form and return it with your donation to:
Westside Family Health Center
1711 Ocean Park Boulevard
Santa Monica, CA 90405

Yes, I want to support Westside Family Health Center and make a healthy difference in the community. Please accept my tax-deductible gift of (circle one):

\$500 \$250 \$200 \$100 \$50 \$25 Other _____

Name _____

Address _____

City _____ State _____ Zip _____

Phone (home) _____ Phone (work) _____

E-mail _____

By Check:

Enclosed please find a check for Westside Family Health Center for \$ _____

By Credit Card:

Please bill my _____ American Express _____ VISA _____ MasterCard

Credit Card # _____ Exp. Date _____

Signature _____

_____ My company will match my gift. (Please enclose form.)

_____ Please keep my name anonymous.

_____ My gift is a tribute. (If you wish WFHC to send an acknowledgement to the person you are honoring, please enclose honoree name, honoree address and occasion.)

Westside Family Health Center, 1711 Ocean Park Boulevard, Santa Monica CA 90405
Admin 310.450.4773 Clinic 310.450.2191 Fax 310.450.0873 www.wfhcenter.org