MAIL-IN DONATION FORM

Please print this form and complete the information below to ensure we can process and acknowledge your gift.

Please mail this completed form to:
Catholic Medical Mission Board
Gift Processing Center
PO Box 37041
Boone, Iowa 50037-0839

DONOR INFORMATION
Full Name: ____________________________________________
Organization Name (Fill this out only if you're making your donation on behalf of an organization): ________________________________

ADDRESS INFORMATION
Address (If you’re making this donation on behalf of an organization, please provide the organization’s address):
_________________________________________________________________________________________________________________________________________________________
City: _____________________________________________ State: __________________________ Zip Code: ______________ Country: ______________
Email: __________________________________________ Phone Number: __________________________

By providing your contact information, you will receive CMMB alerts and other ways to get involved. You may unsubscribe at any time.

PAYMENT OPTIONS
One Time Gift Amount: __________________________
☐ I’m enclosing my check made payable to Catholic Medical Mission Board.
☐ Please charge my credit/debit card:
   ○ MasterCard  ○ Visa  ○ American Express  ○ Discover
   Cardholder’s Name: __________________________________________
   Card Number: __________________________________________
   Expiration Date: __________________________________________

BECOME A MONTHLY DONOR
Your monthly gift can make a life-changing difference!
☐ YES! Please bill my credit/debit card in the amount of $_____________ per month.
☐ YES! I’d like to make a monthly gift in the amount of $_____________ per month using my banking account. I’ve attached a voided check from the account to use.

You may change/cancel this amount at any time by contacting CMMB by email at info@cmmb.org or by phone at 1-800-678-5659.

I WANT TO SUPPORT
☐ Where It Is Needed Most: Your gift will be used to provide help where it is needed most.
☐ Other*: __________________________________________

*Please also indicate the cause’s name on the memo line of your check (e.g. COVID-19 Response). If CMMB is not receiving funds for the cause you indicated, your gift will be applied to Where It Is Needed Most.

TRIBUTE GIFTS
I wish to make a gift ☐ in memory of ☐ in honor of:
Name: __________________________________________

LEGACY SOCIETY
Through a planned gift, you can leave a legacy of love.
☐ Please send me more information about how I can remember CMMB in my will or trust.
☐ I have already included CMMB in my estate plans.