

**InterFaith Health Clinic
Online Donation Form**

Each patient visit costs the clinic \$55. On average, patients pay \$15.

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

- Check Enclosed
- Charge to Credit Card: _____ Visa _____ MasterCard

Card # _____ Expiration Date: _____

Total to be charged: _____

Name as it appears on credit card: _____

This gift is made:

In memory of: _____

In honor of: _____

Please send acknowledgement of my gift to:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Name on Acknowledgement Card: _____

(if not specified, we will use your name as it appears on your check or credit card)

Please fill out this form and mail to:

**Donations
InterFaith Health Clinic
315 Gill Ave.
Knoxville, TN 37917**