



## Donation Form

We are grateful for your support of the Care Providers of Minnesota Foundation.  
Please use this form for Donations.

### Donor Information

Name: \_\_\_\_\_  
Organization Name (if applicable): \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

How would you like to be recognized in our donor acknowledgement?  
(Your name, name of your company or organization, dedicated to, in honor of...)

\_\_\_\_\_

Please check here if you would like your gift to be anonymous:

### I would like to donate by:

Check

Gift Amount Enclosed: \_\_\_\_\_

Checks should be made payable to "Care Providers of Minnesota Foundation"

Visa/MC

American Express

Gift Amount: \_\_\_\_\_

Card #: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

AVS Code\*: \_\_\_\_\_

\*3-digit # on Visa/MC; 4-digit # on American Express

Name as it appears on Card: \_\_\_\_\_

Card Billing Address (if different than above): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature: \_\_\_\_\_

\_\_\_\_\_

**Please mail this completed form and check (if applicable) to:**

**Care Providers of Minnesota Foundation**

**7851 Metro Parkway, Suite 200**

**Bloomington, MN 55425**

All gifts are tax deductible to the full extent allowed by law.