



(PLEASE PRINT)

I would like to donate the following amount \$ \_\_\_\_\_

Check one:  Single       Monthly       Quarterly       Bi-Annually       Annually  
(contributions other than single will be invoiced at each period)

### Donating by Check

Please make your check payable and mail to:  
Hispanic Dental Association Foundation  
3085 Stevenson Drive, Suite 200  
Springfield, IL 62703

### If donating by Credit Card, please provide us with the following information:

Circle your type of Credit Card :

VISA     Master Card     American Express

Credit Card Number \_\_\_\_\_

Exp Date: \_\_\_\_\_ Security Code: \_\_\_\_\_

Name on the Card: \_\_\_\_\_

### Please provide the following information in full:

Check Your Preferred Title:  Ms.     Mrs.     Mr.     Dr.     None     other \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Country \_\_\_\_\_ Email \_\_\_\_\_

I do not want to receive email updates

Daytime Phone: \_\_\_\_\_ Evening Phone \_\_\_\_\_

Identify EXACTLY how your name should be recognized:

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The Hispanic Dental Association Foundation is recognized by the IRS as a 501(C) charitable organization.  
All contributions are tax deductible as allowed by law.