Please return this form to:

DDC Clinic
14567 Madison Rd.
Middlefield, OH 44062

DDC Clinic~Center for Special Needs Children

Your Donation is tax deductible to the event permitted by law under Section 501(c) (3) of the Internal Revenue Code.

Donor Information:

Name _____

Address _____

City _____ State _____ Zip Code_____

Country_____

Daytime Phone ( ) _____ Evening Phone ( ) _____

E-mail Address _____

☐ Yes, I would like to be added to your mailing list.

☐ Yes, I would like to be added to your e-mail list.

☐ I would like to request a speaker for a presentation to a community group / organization.

☐ I wish to volunteer to assist in the growth of the DDC Clinic.

Gift Information:

☐ Enclosed is my gift of $_____ (Please make check payable to DDC Clinic)

☐ Please charge my Credit Card for $_____ ☐ MasterCard ® ☐ Visa ®

Credit Card Number _____

Expiration Date _____Security Code_____

Name on Card _____

Signature _____

Please bill my Credit Card: ☐ One Time Only ☐ Monthly ☐ Quarterly ☐ Annually

My gift will be matched by my company:

Company Name _____

Contact Name _____Contact Phone ( ) _____

☐ Please have a planning officer contact me about stock donations and other planned giving options.

☐ Please make the donation in memory / honor of:

Name _____

Please acknowledge my gift to:

Name _____

Address _____

City _____ State _____ Zip Code_____