

California Vision Foundation

A 501 (c)(3) Tax-Exempt Charitable Organization
Federal Tax ID Number 68-0198414

“Dedicated to preventing vision loss and enhancing eye health through public education and the provision of services to medically underserved Californians.”

Donation Form

Donor Name: _____ License #: _____

Mailing Address: _____

_____ Postal Code: _____

Phone Number: _____ Fax Number: _____

E-mail Address: _____

1. What is the amount of your gift?

- \$50 \$100
 \$250 \$500
 Other (please specify): _____

(Please make your check payable to the California Vision Foundation and attach to this form.)

Check # _____

Credit Card:

- Visa Master Card American Express

Name as it appears on card: _____

Card Number: _____ Expiration _____

I would like to donate to the California Vision Foundation (CVF) through my monthly California Optometric Association dues. Please bill me a monthly amount of:

- \$10 \$20 other \$ _____
 \$15 \$25

2. Do you require a charitable donation receipt?

- Yes No

3. Do you wish to remain anonymous?

- Yes No

Donor Signature

Date

PLEASE RETURN THIS FORM TO:
California Vision Foundation
2415 K Street
Sacramento, CA 95816