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: _____

City_____ 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
Email: billing@coavision.org -OR- Secured Finance Fax: 916 469-2896