



PRASAD[®]
holistic | sustainable | life-changing

*Children's Dental
Health Program*

Donation Form

Choose donation amount

☐ \$50 ☐ \$100 ☐ \$500 ☐ \$1,000 ☐ \$1,500 ☐ Other _____

Choose donation type

☐ Monthly donation as a PRASAD CDHP Partner ☐ One-time donation

Choose payment type

- ☐ By credit card ☐ Check enclosed
- ☐ Automatically from my credit card
- ☐ Automatically from my checking account for U.S. donors only. I have enclosed a voided check
- ☐ I will send a check each month. Please mail me 12 envelopes.

Please charge my credit card ☐ Visa ☐ MC ☐ AMEX ☐ Discover

Card Number _____ Exp Date _____

**Required Information*

*Name: _____

*Address: _____

*City: _____ State: _____

*Zip: _____ Country: _____

Phone: _____

E-mail: _____

For PRASAD use only

Signature: _____

Signature required for credit card and checking account withdrawal

☐ Please put me on your E-mail list

Thank you!