



HAMM CLINIC<sup>SM</sup>

A NON-PROFIT MENTAL HEALTH RESOURCE

NAME

ADDRESS

CITY

STATE

ZIP

PHONE

HOME  OFFICE  CELL

*Contribution Amount* \$ \_\_\_\_\_

*Please use my gift to support:*

- CLIENT CARE    TRAINING AND EDUCATION  
 COMMUNITY OUTREACH    RESEARCH  
 UNRESTRICTED

**Payment by:**  Check enclosed made payable to Hamm Clinic

VISA    MasterCard

CARD NUMBER

EXPIRATION DATE

NAME ON CREDIT CARD (PLEASE PRINT)

SIGNATURE/DATE

My gift is:  in honor    in memory of \_\_\_\_\_

Please contact me to:  set up an annual giving schedule

discuss an endowed/planned gift

I have already included Hamm Clinic in my estate planning

*Hamm Clinic would like to acknowledge your gift. Please print your name as you would like it to appear in our annual report* \_\_\_\_\_

I prefer that my gift remain anonymous

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