



## Doctors Without Borders Field Partner Monthly Giving Program Enrollment Form

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone \_\_\_\_\_

**Please email me the latest updates from the field and free e-newsletter at:**

Email Address \_\_\_\_\_

I would like to make an **automatic monthly gift of:**

\$10    \$15    \$30    \$50    \$Other \_\_\_\_\_

**Option 1: By Credit Card**

Please charge my gift each month to:

Visa    MasterCard    American Express    Discover

Credit Card Number \_\_\_\_\_ Expiration Date \_\_\_\_\_

Name (as it appears on your credit card) \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Option 2: By Direct Debit**

If you would like to pay by direct debit from your checking account each month, please enclose a voided check. Your future monthly gifts will be transferred from your checking account.

Signature \_\_\_\_\_ Date \_\_\_\_\_

*Thank you for your generosity. All contributions are tax deductible. Doctors Without Borders USA, Inc. is recognized as tax exempt under section 501(c)(3) of the Internal Revenue Code, Tax ID # 13-3433452.*

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