



AFFILIATED COMMUNITY
HEALTH FOUNDATION

Supporting Health Careers in Our Communities.

CONTRIBUTION FORM

YES! I would like to support ACHF

NAME _____

ADDRESS _____

CITY _____

ZIP _____

EMAIL _____

CASH/CHECK (payable to ACHF) Total Amount: \$ _____

CREDIT CARD Total Amount: \$ _____

Credit Card: Discover® MasterCard® Visa®

Card Number: _____

V.I.N. Code: _____
(V.I.N. Code is the 3 digit number on the back of your credit card, located in the signature card line.)

Card Expires: _____/_____
Month Year

Card Holder's Name: _____

Signature: _____

I wish to remain anonymous.

Please contact me about other contributions, such as stock transfers.

Please return this form and your payment to:

Affiliated Community Health Foundation

Attn: Accounting

101 Willmar Avenue SW

Willmar, MN 56201