Donation Record Form

Please fill out and enclose/bring with your donation.
An acknowledgement of your gift will be mailed to you. Thank you.

Name ____

Representing (Organization Name) ________________________________

Address ____

City ____________________________________ State _______Zip __________

Phone (home) _________________________(cell) ____________________________

E-mail Address ____

Description of Donation: ____

____

Value (if desired) $____

Thank you! Your gift to our children is deeply appreciated.

Please deliver items to:
Kalispell Child & Family Therapy Clinic
322 2nd Ave W, Suite A
Kalispell, MT 59901
(406) 755-4022
Monday through Friday, 8 am – 5 pm

Received by__________________________________ Date_____________________

intermountain
Caring Solutions ▪ Strong Families ▪ Healthy Communities