

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:

Development Building
500 S. Lamborn St
Helena, MT 59601

or

Child & Family Therapy Clinic
322 2nd Ave W Suite A
Kalispell, MT 59901

8am – 5pm
Monday through Friday
(406) 457-4804

Received by _____ Date _____