



Monthly Giving Form

Yes! I would like to support Hospice & Palliative Care Charlotte Region each month with a gift of:

\$25 \$35 \$50 \$100 Other: \$ _____

Dr./Mr./Mrs./Ms. _____

Address _____

Home phone _____ E-mail _____

*Please charge my account on the **5th** day of the month.*

MasterCard Visa American Express Discover (choose one)

Card # _____ Exp. date _____

Cardholder name _____

Signature _____

Please mail to:

Hospice & Palliative Care Charlotte Region
1420 East Seventh Street
Charlotte, NC 28204

This authorization is to remain in effect until Hospice & Palliative Care Charlotte Region (HPCCR) has received notification from me of its termination in such time and in such manner as to afford HPCCR a reasonable opportunity to act on it.