



FIELD PARTNER

Field Partners Monthly Giving Enrollment Form

Name _____

Address _____

City, State, and ZIP _____

Telephone _____ Email _____

I want to become a Field Partner and help Doctors Without Borders volunteers bring medical care to victims of wars, natural disasters, and epidemics every day through a monthly gift.

I would like to make an automatic monthly gift of \$ _____

OPTION 1: BY CREDIT CARD

Please charge my gift each month to:

Visa MasterCard American Express Discover

Credit Card Number _____ Exp. 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 send a voided check and mail it with this form to:

Doctors Without Borders USA

P.O. Box 5030

Hagerstown, MD 21741-5030

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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