

Pre-authorized Monthly Donation – Service Authorization Agreement

I (we) authorize **Siloam Family Health Center** and the financial institution listed below to electronically debit my (our)

Checking account or Savings account specified below:

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Donor's Name (PLEASE PRINT)

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Donor's Mailing Address (PLEASE PRINT)

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(Area Code) and phone number

Email Address

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Bank Name and Address of Branch

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Bank Transit/ABA Number

Checking/Savings Account Number

I want to pledge a monthly gift of **\$250** (equals \$3,000 annually for our Gift of a Day program. This covers the unfunded costs of the clinic for one day.)

I want to pledge a monthly gift of \$100

I want to pledge a monthly gift of \$75

I want to pledge a monthly gift of \$50

I want to pledge a monthly gift of \$25

I want to pledge a monthly gift of \$\_\_\_\_\_.

The automatic draft shall begin during this month, \_\_\_\_\_ and will recur on the 1<sup>st</sup> of each month thereafter until I give 30 days written notification to stop the automatic draft to both Siloam Family Health Center and the bank listed above. Please allow 45 days for the first draft to appear.

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Authorized Signature

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Date

**Please mail this form with your voided check to:**

Siloam Family Health Center  
820 Gale Lane  
Nashville, TN 37204

Siloam Family Health Center is a 501c3 organization. All donations are tax-deductible to the extent allowable by law.  
For further information, please phone (615) 298-5406 ext. 137.

*Thank you for helping "to share the love of Christ by serving those in need through health care."*