

### Information about you:

Full Name:

.....

Organisation Name & Position:  
(if donation is on behalf of a business)

.....

Address:

.....

.....

.....

Phone:

[Fixed]..... [Mobile].....

Email:

.....

Date of Birth:

\_\_ / \_\_ / \_\_\_\_

## Yes!

I would like to make a donation. I am proud to help CareFlight continue to perform their life-saving work.

Please accept my donation of:

\$ \_\_\_\_\_

Is your donation linked to a particular celebration, event, or in memoriam?

Yes

No

If yes, please provide us with any relevant details.

.....

.....

.....

### Payment Details (please tick your payment method)

#### OPTION 1: CREDIT CARD

VISA       MasterCard       AMEX

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Card Expiry: \_\_ / \_\_

Name:.....  
(as it appears on the Card)

Cardholder Signature: .....

#### OR OPTION 2: PERSONAL CHEQUE

#### OR OPTION 3: MONEY ORDER

#### OR OPTION 4: CASH

Please return your completed form to:

**CareFlight**  
GPO BOX 9829  
In Your Capital City

Fax 1300 788 786

*CareFlight is a not for profit medical organisation. Our mission is to save lives, speed recovery and serve the community by providing the highest standard of rapid response critical care.*

CareFlight Ltd. ABN 18 210 132 023

[www.careflight.org](http://www.careflight.org)

I would like more information on making regular donations to CareFlight.

I would like more information on how I can include CareFlight in my Will.

I would like to be kept informed of how my contribution is helping save lives.