

Information about you:

Full Name:

.....

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

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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.

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.....

Payment Details (please tick your payment method)

OPTION 1: CREDIT CARD

VISA MasterCard AMEX

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

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