Doctors Without Borders
Field Partners Monthly Giving Enrollment Form

Name ____________________________________________________
Address ____________________________________________________
City _______________________________________________________
State ___________________ Zip Code __________________________
Telephone __________________________________________________
E-mail ______________________________________________________

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 (MM/YY) _________
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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