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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