2020
CELEBRATING
LIFE Gala

PREGNANCY CARE CENTER

Name _____

- ❑ Tour or volunteer at the pregnancy care center
- ❑ One-time tax deductible gift of $ _____
- ❑ Monthly gift:
  - ❑ $50 Pregnancy test, STI test, & options counseling
  - ❑ $100 Ultrasound & radiologist report
  - ❑ $500 Material aid earned thru parenting support programs
  - ❑ $1200 Total cost to save a baby's life from abortion
  - ❑ Building Fund $ _____
  - ❑ Other $ _____

Comments: _____

_____

MAKE CHECKS PAYABLE TO PREGNANCY CARE CENTER
SEE REVERSE FOR CREDIT CARD CONTRIBUTIONS

Name _____

Address _____

City/ST/Zip _____

Email _____

Telephone _____

GIVING METHOD

❑ Please charge my credit card once for $ _____

❑ I authorize Pregnancy Care Center to establish a monthly gift transfer of $ _____

❑ Please set up my donation to be given on the ❑ 5th or ❑ 20th *(check one)* of each month using my:

- ❑ Checking Acct. *(voided check enclosed)*
- ❑ Savings Acct. *(voided deposit ticket enclosed)*
- ❑ Credit Card ❑ VISA ❑ MasterCard ❑ DISCOVER

Credit Card Number _____

Expiration _____ CVV _____

Signature _____ Date _____

Make changes anytime by contacting the Pregnancy Care Center.
(210) 614-5433 or info@sapregnancy.org