

PRASAD
Philanthropic Relief, Altruistic Service And Development
*Children's Dental
Health Program*

I would like to pledge a monthly gift to support PRASAD Children's Dental Health Program Inc. by having an automatic withdrawal from my checking/savings account each month.

Pledge amount \$ _____ per month.

Name _____

Address _____

City _____ State _____ Zip _____

Country _____

Home Phone () _____ Work Phone () _____

Fax () _____ E-Mail _____

My request shall remain in effect unless and until I notify PRASAD Children's Dental Health Program Inc., or my bank, that I wish to end or modify this agreement.

All gifts originating as ACH transactions comply with U.S. law.

Signature _____ Date _____

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If you would like to discuss increasing, decreasing or suspending your monthly gift, please call us at 845.434.0376, or write to us at:

PRASAD Children's Dental Health Program Inc.
465 Brickman Road
Hurleyville, N.Y. 12747
prasadcdhp@prasadcdhp.org

All gifts originating as ACH transactions comply with U.S. law.

Return the completed enrollment form, along with a voided check from the account you wish your automatic withdrawal to be deducted from, to the address listed above.

Your first direct bank payment will occur in 4-6 weeks. (Must use U.S. Bank account.)

Record your donation amount here: \$ _____

Your contribution is fully tax deductible to the extent permitted by law. PRASAD Children's Dental Health Program Inc. acknowledges that no goods or services were received by the contributor in exchange for this contribution. PRASAD Children's Dental Health Program Inc. is a 501 (c) (3) tax-exempt organization. A copy of the latest annual report of PRASAD Children's Dental Health Program Inc. can be obtained from our office, or, from the Office of the Attorney General by writing to the Charities Bureau, 120 Broadway, New York, N.Y. 10271