



U.S. Department
of Veterans Affairs

**Veterans Health Care System
of the Ozarks
Fayetteville, Arkansas**

Donations Form

___ Cash / Check

___ Non-Cash

Date: _____

Donor Information

Donated by: (Please circle one) Organization /Post or Chapter Individual

Organization, Post, Chapter or Individual's Name: _____
(Please Print)

Mailing Address: _____

City/State/Zip: _____

Person Delivering Item: _____

Designated Use of Cash/Check Donation: _____

(Please Print)

Non-Cash Donation Information

Please list - give a brief description	Estimated value
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

FOR OFFICE USE ONLY

Donor ID: _____ Posted to Non-Cash Report : _____ TY Sent: _____

Amount: _____ Check # _____ Check Date _____