CDTC TRANSFORMERS

transforming the lives of children

Transformers Commitment Form

Contact information:

Name: ______________________ Birthdate: ____________ Membership Start Date: __________

Home Address: ____

City: ____________________________ State: _________ Zip: _____________________

Company: ______________________________ Job Title: __________________________

Work Address: ____

City: ___________________________ State: ____________ Zip: __________________

Preferred Phone Number: ________________ Preferred E-mail: ___________________________

Please mail to my: ❍ Home Address ❍ Work Address

Payment Information:

Your donation of $50/month helps to cover the gap in the cost of medical care for 1 child for our Primary Care Clinic.

I want to help ___ child(ren). (1 child = $50/month; 2 children = $100/month; 3 children = $150/month)

I prefer to have my donation billed: ❍ Monthly ❍ Annually

Please make checks payable to Children's Diagnostic & Treatment Center

I authorize CDTC to charge my credit card in the amount of $___________

Name (as it appears on credit card): ____

Billing Address (if different): ____

City: __________________________________ State: _________ Zip: __________________

Credit Card Number: ________________________________ Exp. Date: ________________

Signature: ____ Date: __________________

Please return this form to: Children's Diagnostic & Treatment Center
Attn: Jessica Vones
1401 South Federal Highway, Fort Lauderdale, FL 33316
or jvones@browardhealth.org

Your membership will continue to renew automatically.
Please notify CDTC to make any changes.