



HOLIDAY CARD ORDERS

Make a lasting gift this holiday season by allowing InterFaith to send holiday cards to your friends and loved ones.

The holidays are a time for us to remember friends, colleagues, and loved ones and to share the blessings of the holiday season. We invite you to share InterFaith's message of health and hope by sending holiday greeting cards to those on your gift list this year, with all the proceeds underwriting comprehensive, affordable health care for the underserved in our community.

Those you honor will receive a hand-addressed card from InterFaith acknowledging that a gift has been made in the recipient's name. All gifts are tax deductible.

A minimum donation of \$10 per honoree is suggested.



To participate in InterFaith's holiday card program, please fill out the form on the back and mail or email it to the Center along with your donation. Alternatively, you may submit your mailing list and make your donation online by scanning the adjacent QR code.



scan to order
holiday cards



Donor name (as you want it to appear on card) _____

Christmas or Holiday (please circle one)

Name of honoree: _____

Mailing address _____

City _____ State _____ ZIP _____

Name of honoree: _____

Christmas or Holiday (please circle one)

Mailing address _____

City _____ State _____ ZIP _____

Name of honoree: _____

Christmas or Holiday (please circle one)

Mailing address _____

City _____ State _____ ZIP _____

Name of honoree: _____

Christmas or Holiday (please circle one)

Mailing address _____

City _____ State _____ ZIP _____

Name of honoree: _____

Christmas or Holiday (please circle one)

Mailing address _____

City _____ State _____ ZIP _____

Name of honoree: _____

Christmas or Holiday (please circle one)

Mailing address _____

City _____ State _____ ZIP _____

If you have additional recipients, attach another sheet or email them to tlamarche@interfaithhealthcenter.org

I would like to support InterFaith Health Center with this gift of \$ _____

Check enclosed (Please make checks payable to InterFaith Health Center)

Please charge my credit card

Credit card number: _____ Exp. date: _____ CVC: _____

Name on card: _____

Billing address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Email: _____

(required)

Signature: _____



Mail this form along with your payment to:

InterFaith Health Center
Attn: Development
315 Gill Ave.
Knoxville, TN 37917