

DATE: _____

Happy Hope Order Form



CUSTOMER INFORMATION

Name: _____
 Email: _____
 Address: _____
 City: _____
 State: _____
 Zip: _____
 Phone: _____

DESCRIPTION	UNIT PRICE	QUANTITY	TOTAL
Outpatient/ER	\$20/3 units	25 minimum \$375 Donation	
Clinic Packets	\$15/unit	100 minimum \$500	
Overnight	\$20/unit	25 minimum \$500	
Long Term Patient	\$25/unit	25 minimum \$625	
*Plus Shipping to your location home or work			
		Total Donation	

Donation Details: CHECK CREDIT CARD

Credit Card Name: _____

Credit Card Number: _____

Expiration Date: _____ CID#: _____