The Turtle Hospital Donation Form

11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	SCOR REHAB RIVERS	Donor Name: Address: City, State, Zip: Phone Number: Amount:	\$			
A th	A thank you letter and/or tax receipt will be sent to the address above.					
If this donation is a gift, please fill out below so we may notify them.						
	Name:					
	Address:					
	City, State, Zip:					
	In Memory of:					
	In Honor of:					
	Occasion:					
Don	ations are tax deduc	tible as permitted b	oy law.			
Please mail checks to :		The Turtle Hospit	al			
		2396 Overseas H	ighway			
		Marathon, FL 330	050			