



Project Pacer International Medical Supplies Donation

Contact Information:

Organization: _____

Name of Contact: _____

Address: _____

Address: _____

City: _____ State: _____ Zip: _____ Country: _____

Email: _____

Phone Number: _____

Gifts of Supplies, Equipment & Medication: (Please no prescription medications or controlled substances)

Item # 1 Make/Model: _____

Description: _____

Estimated Value: _____

Item # 2 Make/Model: _____

Description: _____

Estimated Value: _____

Item # 3 Make/Model: _____

Description: _____

Estimated Value: _____

Thank you so much for your donation!