INDIVIDUAL DONATION REQUEST FORM:

Name of person requesting donation: _____

Contact Info:

_____

Who is the donation for?

_____

_____

Location of recipient – country/state:

_____

Diagnosis of recipient:

_____

Reason/Summary of why recipient needs assistance:

_____

_____

_____

_____

Does recipient have insurance? _____

Who have you or the recipient requested assistance from recently/in the past? _____

Has recipient ever received donations/assistance (other than insurance) in the past? _____

If so, from whom, and for what?

_____

_____

_____

Description/Summary of how this will benefit/better the life of the recipient:

_____

_____

_____

_____

2830 California St. Torrance, CA 90503 · Phone: 310-618-0111

Email typed form to: donations@convaid.com

Does recipient currently have a wheelchair? If so, what brand? _____

What type of Convaid (with all needed supports/accessories) is recipient in need of?

_____

_____

What makes Convaid your brand of choice?

_____

_____

_____

_____

What makes the Convaid product your product of choice?

_____

_____

_____

Would you or the recipient be willing to raise money to go towards the donation or pay for part of the wheelchair?

_____

_____

_____

If not, why?

_____

_____

_____

_____

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