Payment Information:

Preferred Frequency of payment:

_____ $30 Monthly

_____ $90 Quarterly

_____ $360 Yearly

Please detach this section and mail it with your tax deductible check payable to:

Chronic Care International

Contact Information:

Mail:

Chronic Care International
9223 Bayberry Rd
LaVista, NE 68128

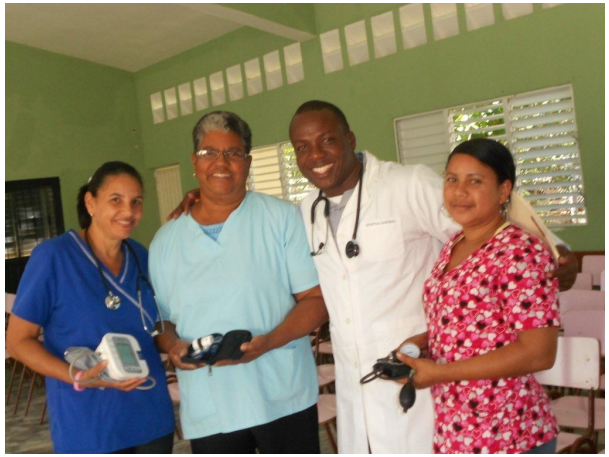
Email:

ChronicCareInternational@gmail.com

Call:

Hans Dethlefs, MD
402-960-2217

Chuck Filipi, MD
402-250-6196



Services Provided

- Education
- Doctor visits
- Medications
- Lab testing
- Community events
- Outreach services
- Electronic data monitoring

diabetes hypertension & other chronic diseases chronic care international

Chronic Care International

Support a Person

With

Diabetes or Hypertension

In the Dominican Republic

Through

Sponsorship

Help fight the largest worldwide epidemic by supporting one person

The Problem

Diabetes: 350 million people

Hypertension: 1 billion people

Heart Attacks
Strokes
Blindness
Kidney Failure
Leg Amputations

Diabetes and hypertension represent the most common chronic diseases in the world. They lead to unnecessary suffering in millions of people. They contribute to heart disease which is the leading killer across the globe. Families are disrupted because parents become disabled and children must leave school to work, which further feeds the cycle of poverty.

The Program

Chronic Care International began its diabetes and hypertension program in the Dominican Republic in 2010.

We treat more than 900 people with diabetes and hypertension through education and high quality medical care.

Healthy Patients

Healthy Families

Healthy Communities

How to Help

By sponsoring an individual you can provide both the motivation and financial support that they need to live a healthy life despite their diabetes or hypertension.

- Through correspondence you can help motivate them in their efforts with diet, exercise, and taking medication regularly.
- $30 per month will cover the cost of the medical care and education that they could not get otherwise.

Your information:

___Mr. ___ Mrs. ___Ms. ___Dr.

Name_____

Date of Birth_____

Gender ___M ___F

Address_____

_____

City_____ State____ Zip_____

Phone 1_____

Phone 2_____

Email_____

Preferred patient gender:

___M ___F ___Either

Prefer patient with:

___Diabetes ___Hypertension ___Either

(Please fill out information on back as well)