# MAIL-IN DONATION FORM

## AMOUNT
- $30
- $50
- $100
- $250
- $500
- $1,000
- $2,500
- $Other $__________

## FREQUENCY
- One Time Donation
- Recurring Donation (Please circle)

### Recurring Donation
- **Donation Day of Month:** 1st or 15th day of the month
- **Donation Frequency:** Monthly Quarterly Annual
- **Number of Payments:** _____________
- **Date of First Donation:** _____________

## DONOR INFORMATION

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Name</td>
<td>_______________________________________________</td>
</tr>
<tr>
<td>Last Name</td>
<td>_______________________________________________</td>
</tr>
<tr>
<td>Address</td>
<td>_______________________________________________</td>
</tr>
<tr>
<td>City</td>
<td>_______________________________________________</td>
</tr>
<tr>
<td>State</td>
<td>_______________________________________________</td>
</tr>
<tr>
<td>Phone #</td>
<td>_______________________________________________</td>
</tr>
<tr>
<td>Zip</td>
<td>_______________________________________________</td>
</tr>
<tr>
<td>Email</td>
<td>_______________________________________________</td>
</tr>
</tbody>
</table>

## PAYMENT INFORMATION

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>CC #</td>
<td>_______________________________________________</td>
</tr>
<tr>
<td>CC Type</td>
<td>Visa AMEX MC Discover</td>
</tr>
<tr>
<td>Cardholder’s Name</td>
<td>_______________________________________________</td>
</tr>
<tr>
<td>Expiration Date</td>
<td>_______________________________________________</td>
</tr>
<tr>
<td>CVC/CVV Code</td>
<td>_________</td>
</tr>
</tbody>
</table>

## ADDITIONAL INFORMATION

### My relationship with PN is?
- I Have PN
- My friend has or had PN
- My family member has or had PN
- I am a healthcare provider: (Please circle)
  - Doctor
  - Nurse
  - Other: ____________________

### How did you hear about us?
- Friend/Family
- Internet/Search
- Event
- Doctor
- Social Media
- Other: ____________________

### Would you like a complimentary Premium Membership subscription?
- Yes, please!
- No, thank you.

*If you donate $30.00 or more, you are eligible for a complimentary one year Premium Membership.*
### CUSTOMIZE YOUR DONATION

I would like to make this donation: (Please fill out additional form for Special Occasion or In Memory/Honorarium)

- [ ] A Regular Donation  
- [ ] Special Occasion  
- [ ] In Memory/Honorarium

### SPECIAL OCCASION

**TRIBUTE TYPE**  
- [ ] Anniversary  
- [ ] Birthday  
- [ ] Bar/Bat Mitzvah  
- [ ] Holiday

### IN MEMORY/HONORARIUM

**TRIBUTE TYPE**  
- [ ] In honor of: _____________________________  
- [ ] In memory of: _____________________________

### NOTIFICANT INFORMATION (WHO WE SHOULD NOTIFY ABOUT YOUR DONATION):

- **First Name:** _____________________________  
- **Last Name:** _____________________________

- **Address:** _____________________________  
- **City:** _____________________________  
- **State:** _____________________________

- **Phone #:** _____________________________  
- **Zip:** _____________________________

- **Email:** _____________________________

### CUSTOM MESSAGE TO APPEAR ON YOUR CARD:

__________________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

**PLEASE MAIL THIS FORM WITH PAYMENT TO:**

*the Foundation for Peripheral Neuropathy*

485 E Half Day Rd Ste 350  
Buffalo Grove, IL 60089-8808