

DONOR INFORMATION

Please print legibly and fill in all information as completely as possible.

Title: Dr. Miss Mr. Mrs. Ms. Other: _____

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Email: _____

PAYMENT INFORMATION

Donation Amount: \$35 \$50 \$100 \$250 Other: \$ _____

Donation Type: One-time donation
 Monthly gift (The selected amount will be charged to your credit card or deducted from your bank account every month.)

Payment by Credit Card:

Credit Card Type:
 VISA MasterCard American Express Discover

Account Number: _____

Expiration Date: _____ CVV: _____

Signature: _____

Payment from Bank Account:

Account Type:
 Checking Savings

Account Number: _____

Bank Routing Number: _____

Payment by Check: Make your check payable to Parent Project Muscular Dystrophy and mail with this form to the address below.

GIFT INFORMATION

This donation is in honor / in memory of: _____

Please provide the individual or family's address: _____

Do you know someone with Duchenne? If so, please select the option that best describes your relationship to them:

Parent Grandparent Family Member Friend Physical or Occupational Therapist Doctor or Researcher
 Other: _____

Additional comments or instructions: _____