Parent Project Muscular Dystrophy

LEADING THE FIGHT TO END DUCHENNE

GIVE

DONOR INFORMATION

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

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

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Email: _____

PAYMENT INFORMATION

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

Donation Type: O One-time donation
O STIR Striving to Impact Research monthly giving program
(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:
O VISA O MasterCard O American Express O Discover

Account Number: _____

Expiration Date: _____

Signature: _____

Payment from Bank Account:

Account Type:
O Checking O 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

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

Additional comments or instructions: _____

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