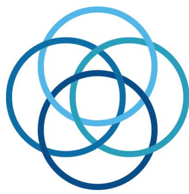

The Foundation For Post-Acute And Long-Term Care Medicine

GIFT AMOUNT

I would like to make a contribution to the Foundation for PA/LTC Medicine in the amount of $ _______________

I would like my contribution to benefit the following: ☐ Unrestricted funds ☐ Futures Program

I would like to make my donation in honor or memory of ____

Sentiments or dedication about honoree to be included on the Wall of Caring:

____

____

CONTACT INFORMATION

First Name: ______________________ Last Name: ___________________________ Credentials: ____________________

Organization Name: ____

Address: ____

City: __________________________________ State: ____________________________ Zip Code: ___________________

Email: ____ Phone: ____

Will your company match your gift to the Foundation for PA/LTC? ☐ Yes ☐ No

BILLING INFORMATION

☐ I have enclosed my check made payable to the Foundation for PA/LTC

☐ Please charge my credit card: ☐ MasterCard ☐ Visa ☐ American Express ☐ Discover

Credit Card No: _______/________/________/_______ Security Code: ______ Expiration Date: ___/____

Name of Cardholder (for corporate cards, please include company name):

____

BILLING ADDRESS (if different from above)

Address: ____

City: ____ State: _____________________ Zip Code: _______________

CARDHOLDER SIGNATURE: ____

Please complete this form and mail it with your check/credit card information to:

The Foundation for PA/LTC, 10500 Little Patuxent Parkway - Ste 210, Columbia, MD 21044

The Foundation for PA/LTC is a 501(c)(3). Your gift is tax-deductible to the full extent allowed by the law.