

GIFT FORM

Thank you for contributing to the Friends Against AIDS

an auxiliary group to The University of Chicago Children's Hospital Pediatric and Infectious Disease Department.

Donor Information

Title____ First Name _____ Middle Initial____ Last Name _____

Company or Institution (if appropriate) _____

Address 1 _____

Address 2 _____

City _____ State____ Zip_____

Phone Number (___) ___ - ___ Email Address _____

Name(s) to be listed for acknowledgement purposes _____

Gift Information

Gift Amount: ___\$500 ___\$250 ___\$100 ___\$50 ___ Other Amount \$ _____

___ A check payable to "Friends Against AIDS" is enclosed

___ Please charge my credit card ___ Mastercard ___ Visa

Card Number _____

Expiration ____ / ____

Name as it appears on the card _____

Commemorative Gift (optional)

Name of Honoree: _____

Other Information: _____

Corporate Matching: Check with your employer to see if they offer gift matching. If your employer does offer this program, your Human Resources department should provide you with a matching gift form to send along with FAA's gift form.

Please return to: Friends Against AIDS
The University of Chicago Comer Children's Hospital
5841 South Maryland Avenue, MC 654
Chicago, IL 60637-1470