the FOUNDATION for PERIPHERAL NEUROPATHY®

DEDICATED to REVERSING the IRREVERSIBLE

Donation -

Amount: ○ **$30** ○ **$50** ○ **$100** ○ **Other:** _____

Frequency: ○ **One Time Donation** ○ **Recurring Donation**

Type of Donation: ○ **A Regular Donation** ○ **Special Occasion/In Memory-Honor:** _____

Donor Information:

First Name: _____ **Last Name:** _____

Address: _____ **City:** _____

_____ **State:** _____

Phone #: _____ **Zip:** _____

Email: _____

Relationship with PN is?:

○ I Have PN
○ I am a healthcare provider: Doctor Nurse Other
○ Friend has/had PN
○ Family member has/had Pn
○ 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.

Cardholder's Name: _____ **CC Type:** Visa AMEX MC Discover

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In Memory/Honorarium

Tribute Type: ○ **In honor of** ○ **In memory of**

Recipient Information:

First Name: _____ **Last Name:** _____

Address: _____ **City:** _____

_____ **State:** _____

Phone #: _____ **Zip:** _____

Email: _____

Custom Message to appear on your card:

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Mail To:

the Foundation for Peripheral Neuropathy
485 Half Day Rd., Suite 350
Buffalo Grove, IL 60089