the FOUNDATION for PERIPHERAL NEUROPATHY®

DEDICATED to REVERSING the IRREVERSIBLE

DONATION

AMOUNT ○ **$30** ○ **$50** ○ **$100** ○ **$250** ○ **$500**
○ **$1,000** ○ **$2,500** ○ **$Other $_____**

FREQUENCY ○ **One Time Donation** ○ **Recurring Donation** (Please circle)

Donation Day of Month: 1st or 15th day of the month

Donation Frequency: Monthly Quarterly Annual

Number of Payments: _____

Date of First Donation: _____

DONOR INFORMATION

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

Address: _____ **City:** _____

_____ State: _____

Phone #: _____ **Zip:** _____

Email: _____

PAYMENT INFORMATION

CC #: _____ **CC Type:** Visa AMEX MC Discover

Cardholder's Name: _____ **Expiration Date:** _____

ADDITIONAL INFORMATION

My relationship with PN is?:

○ I Have PN
○ My family member has or had PN
○ Other: _____
○ My friend has or had PN
○ I am a healthcare provider: (Please circle)
Doctor Nurse 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.

*If you donate $30.00 or more, you are eligible for a complimentary one year Premium Membership.

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CUSTOMIZE YOUR DONATION

I would like to make this donation: (Please fill out additional form for Special Occasion or In Memory/Honorarium)

○ **A Regular Donation** ○ **Special Occasion** ○ **In Memory/Honorarium**

SPECIAL OCCASION

TRIBUTE TYPE ○ Anniversary ○ Birthday ○ Bar/Bat Mitzvah ○ Holiday

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:

_____

_____

_____

_____

_____

MAIL TO:

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