the FOUNDATION for
PERIPHERAL NEUROPATHY®
DEDICATED to REVERSING the IRREVERSIBLE

MAIL-IN DONATION FORM

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:** ______________________________

CVC/CVV Code: _______

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: ______________________________

NOTIFICANT INFORMATION (WHO WE SHOULD NOTIFY ABOUT YOUR DONATION):

First Name: _____________________________________ **Last Name:** _________________________________

Address: _______________________________________ **City:** _______________________________________

_______________________________________ **State:** _______________________________________

Phone #: _______________________________________ **Zip:** ____

Email: ____

CUSTOM MESSAGE TO APPEAR ON YOUR CARD:

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PLEASE MAIL THIS FORM WITH PAYMENT TO:

the Foundation *for* Peripheral Neuropathy
485 E Half Day Rd Ste 350
Buffalo Grove, IL 60089-8808