# Parent Project Muscular Dystrophy

**LEADING THE FIGHT TO END DUCHENNE**


## DONOR INFORMATION

*Please print legibly and fill in all information as completely as possible.*

Title: O Dr. O Miss O Mr. O Mrs. O Ms. O Other _____

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Email: _____

## PAYMENT INFORMATION

Donation Amount: O $35 O $50 O $100 O $250 O Other: $ _____

Donation Type: O One-time donation
O STIR Striving to Impact Research monthly giving program
*(The selected amount will be charged to your credit card or deducted from your bank account every month.)*

**Payment by Credit Card:**

Credit Card Type:
O VISA O MasterCard O American Express O Discover

Account Number: _____

Expiration Date: _____

Signature: _____

**Payment from Bank Account:**

Account Type:
O Checking O Savings

Account Number: _____

Bank Routing Number: _____

**Payment by Check:** Make your check payable to *Parent Project Muscular Dystrophy* and mail with this form to the address below.

## GIFT INFORMATION

O This donation is in honor / in memory of: _____

Do you know someone with Duchenne? If so, please select the option that best describes your relationship to them:
O Parent O Grandparent O Family Member O Friend O Physical or Occupational Therapist O Doctor or Researcher
O Other: _____

Additional comments or instructions: _____

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