Parent Project Muscular Dystrophy

JOIN THE FIGHT. END DUCHENNE.

GIVE

DONOR INFORMATION

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

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

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Email: _____

(Required for all credit card donations)

PAYMENT INFORMATION

Donation Amount: ☐ $50 ☐ $100 ☐ $150 ☐ $250 ☐ Other: $ _____

Donation Type: ☐ One-time donation

☐ Monthly gift (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:

☐ VISA ☐ MasterCard ☐ American Express ☐ Discover

Account Number: _____

Expiration Date: _____ CVV: _____

Signature: _____

Payment from Bank Account:

Account Type:

☐ Checking ☐ 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

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

Please provide the individual or family's address: _____

Do you know someone with Duchenne? If so, please select the option that best describes your relationship to them:

☐ Parent ☐ Grandparent ☐ Family Member ☐ Friend ☐ Physical or Occupational Therapist ☐ Doctor or Researcher

☐ Other: _____

Additional comments or instructions: _____

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