



AMERICAN ACADEMY OF HOSPICE AND PALLIATIVE MEDICINE

# MAIL-IN DONATION FORM

## GIFT INFORMATION

### I Choose To Donate

\$50       \$100       \$250       \$500       \$1000       Other \$ \_\_\_\_\_

Name \_\_\_\_\_

Business Name \_\_\_\_\_

### (OPTIONAL)

Address \_\_\_\_\_

City/State/ZIP \_\_\_\_\_

Email Address \_\_\_\_\_ Preferred Name for Recognition \_\_\_\_\_

I would like my donation to remain anonymous

### I WOULD LIKE MY DONATION TO SUPPORT:

- Innovation Fund
- Hearst AAHPM Leadership Scholars Fund
- International Physician Scholarship Fund
- Palliative Medicine Access Fund
- Pediatric Scholarship Fund

My check is enclosed (Please make payable to American Academy of Hospice and Palliative Medicine)

A one-time donation. Please charge my:

Credit Card number: \_\_\_\_\_ CSC Code \_\_\_\_\_ Expiration Date \_\_\_\_\_

Name on Card: \_\_\_\_\_ Signature \_\_\_\_\_

A monthly donation. Please deduct \$ \_\_\_\_\_ from my credit card.

## HONOR OR MEMORIAL GIFT INFORMATION

### (OPTIONAL)

This gift is: \_\_\_\_\_

in honor of \_\_\_\_\_

in memory of \_\_\_\_\_

## MAIL TO



AMERICAN ACADEMY OF HOSPICE AND PALLIATIVE MEDICINE

### AAHPM

P.O. Box 3781  
Oak Brook, IL 60522-3781

AAHPM is exempt under section 501(c)(3) of the IRS.. This gift is tax deductible.

**AAHPM THANKS YOU FOR YOUR GENEROUS SUPPORT.**