

MAIL-IN DONATION FORM

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I Choose To	o Donate						
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I WOULD L	IKE MY DONA	ATION TO SUP	PORT:				
☐ Greatest Need				International Physician Scholarship Fund			
☐ Leadership Fund				☐ Hospice and Palliative Medicine Access Fund			
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My check is	s enclosed (Ple	ase make paya	ble to America	n Academy of I	Hospice an	d Palliative Medicine)	
A one-time	donation. Plea	ase charge my:					
Credit Card number:				CSC	Code	Expiration Date	
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HONOR OF	R MEMORIAL (GIFT INFORMA	ATION				
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This gift is:							
in honor of							
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MAIL TO



AAHPM

Attn: Development Funds PO Box 88019

Chicago, IL 60680-1019

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

AAHPM THANKS YOU FOR YOUR GENEROUS SUPPORT.