



Giving options for the PAFP Foundation:

I would like to give to:

<input type="checkbox"/> Where the Need is Greatest	\$ _____
<input type="checkbox"/> Student Initiatives	\$ _____
<input type="checkbox"/> National Scholarships	\$ _____
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<input type="checkbox"/> Education	\$ _____
<input type="checkbox"/> PA IPIP (Improving Performance in Practice)	\$ _____

Restricted gift to Foundation:

Tribute gift

In honor of _____ \$ _____

In memory of _____ \$ _____

Total Donation Amount \$ _____

First and Last Name _____

Street Address _____

City _____

State _____ Zip Code _____

I prefer to make my donation by:

Check or Money Order (made out to "PAFP Foundation")

Credit Card (please enter information below)

American Express MasterCard Visa

Credit Card Number _____ Exp. Date _____

Security Code _____

Billing Address _____

City, State, and Zip _____

Signature _____

Please mail your gift to:

PA Academy of Family Physicians Foundation, 2704 Commerce Drive, Suite A, Harrisburg, PA 17110