



DONATION FORM

Donor Information

Mr. Ms. Mrs. Dr. Rev. _____

Home Address : _____

Phone: () _____

Email Address: _____

Credit Card Billing Information

Name as it appears on Credit Card: *(First / Middle Initial / Last)*

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

Credit Card (*Visa, Master Card, American Express*): _____

Expiration Date (*MM/DD/YY*): _____

Donation Amount: \$50__ \$100__ \$500__ \$1,000__ Other \$ _____

Is this a recurring donation? Yes__ No__

If so, how often would you like to contribute?

Monthly__ Annually__ Other__

I authorize this card to be used for my donation.

X _____

Authorized Signature

Date

A receipt will be mailed to you at your mailing address indicated above.

My employer's matching donation form is enclosed: Yes__ No__

Please send the completed donation form to:

The John Fair III Spinal Cord Injury Foundation

9119 Highway 6, Suite 230, Mailbox #116, Missouri City, Texas 77459

Phone: 713-253-5084 • Email: Info@johnfair.org