Donation Form

I would like to make a donation of $_________ to support the activities of PHA and/or a donation of $ ____________ to support PHA's research agenda.

Name(s)____

Address____

City______________________________________ State____________ Zip_____________

Phone_________________ Fax__________________ E-mail__________________________

□ patient □ caregiver □ parent of minor child with PH □ other _______________________
□ medical professional (title and affiliation): _______________________________________

Payment:
□ My contribution is enclosed. (check payable to "PHA")
□ Please charge my gift to my: □Visa □MasterCard □AmEx □Discover
Account Number: _______________________________ Expiration Date: _______________
Name: __________________________________ Signature _________________________
As it appears on the account

Optional:
□ I want to provide ongoing support by joining PHA's Sustainer's Circle with a monthly gift of $_____________. I authorize PHA to charge my credit card (information above) on the 15th of every month. I understand that I am free to increase, decrease, or stop my monthly gifts at any time by contacting PHA at 301-565-3004 x116.

My donation is in □ honor of ____________________________ or
□ memory of ____________________________ Date deceased _______________

If you would like us to notify someone of this honor/memorial donation, please provide their name and mailing address:

____

____

Special instructions, if any: ____

□ Please see if my donation is eligible for a matching gift from my (or my spouse's) employer. The company name: _____________________________. PHA will contact you if your donation is eligible.

□ Please send me information on legacy planning.

Please return to:
PHA • 801 Roeder Road, Suite 400 • Silver Spring, MD 20910 • Fax: 301-565-3994 WEB