

**YOUR GIFT ADVANCES THE SCLERODERMA FOUNDATION'S MISSION OF SUPPORT, EDUCATION, AND RESEARCH**

First Name: \_\_\_\_\_ M.I.: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

City: \_\_\_\_\_ ST/Province: \_\_\_\_\_ Zip: \_\_\_\_\_ Country: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_

**GIFT TYPE**

- A general gift to help in the fight against scleroderma.
- A **tribute** gift to honor a friend, family member, or loved one.
- A **memorial** gift to remember a friend, family member, or loved one.

**Please use my gift:**  Where needed most  Research  Education & Support  Conference Scholarships  Awareness

Tribute/Memorial First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Please send a notification of my tribute/memorial gift to:

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

City: \_\_\_\_\_ ST/Province: \_\_\_\_\_ Zip: \_\_\_\_\_ Country: \_\_\_\_\_

Email: \_\_\_\_\_

Message: \_\_\_\_\_

**How much would you like to give?**

\$25  \$50  \$75  \$100  \$250  Amount \$ \_\_\_\_\_

**Would you like this to be a recurring monthly donation?**  YES  NO

Please, charge my card every month for:  one year  two years  three years

For an additional **\$25 annual fee**, please enroll me as a **member** of the Scleroderma Foundation.

**YOUR BILLING INFORMATION** (if different from above):

First Name: \_\_\_\_\_ M.I.: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

City: \_\_\_\_\_ ST/Province: \_\_\_\_\_ Zip: \_\_\_\_\_ Country: \_\_\_\_\_

Name on Credit Card: \_\_\_\_\_

Account Number: \_\_\_\_\_ Exp. MM/YY: \_\_\_\_\_ CVV: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please make checks payable to the Scleroderma Foundation, and mail this form to:  
Scleroderma Foundation, 300 Rosewood Drive, Suite 105, Danvers, MA 01923-1389.

(800) 722-HOPE [4673] – [www.scleroderma.org](http://www.scleroderma.org)

