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| Please complete this donor form and mail it with your contribution to:  UCSF Foundation  PO Box 45339  San Francisco, CA 94145-0339 |

**Contact Information**

|  |  |  |
| --- | --- | --- |
| Name: |  | |
| Address: |  | |
| City, State, Zip: |  | |
| Phone: | (Day) | (Evening) |
| Email: |  | |

**Donation Information**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **I would like to make a donation in the amount of:** | | | | | | | | |
| □ $1,000 | □ $500 | □ $250 | | □ $100 | | □ $50 | | □ Other: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­ |
| □ I have enclosed a check for $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ made payable to the **UCSF Foundation**. | | | | | | | | |
| □ I authorize the UCSF Foundation to collect my gift of $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ on my credit card: | | | | | | | | |
| □ Visa | | | □ MasterCard | | | | □ American Express | |
| Credit Card Number: | | | | | | | Expiration Date: | |
| Cardholder Name: | | | | | Cardholder Signature: | | | |

**Designation: Please designate my gift to the following fund/program:**

|  |  |
| --- | --- |
| □ Bodenheimer Legacy Fund | □ Jonathan Rodnick Memorial Fund |
| □ Clinician Consultation Center | □ Office of Developmental Primary Care |
| □ Clínica Martín Baró, a student-run clinic | □ UCSF Students Homeless Health Project |
| □ If you would like to designate your gift for a specific purpose, an individual doctor, researcher or program for example, please include that information here: | |

**Dedication: I am making this gift in:**

|  |  |
| --- | --- |
| □ Honor of: | □ Memory of: ­­­­­­­­­­­­­­­­­ |
| Please notify: | |
| Address: | City, State, Zip: |

**Other**

|  |
| --- |
| □ My company has a Matching Gifts Program: |
| □ Please contact me about my interest in making a bequest or planned gift. |
| □ Please keep my gift anonymous |

**Thank you for your support!**

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