



Donation Form

I would like to Donate the following amount \$ _____

Check one: Monthly Single

Donating by Check, please mail your check to:

Kids Against Cancer • P.O. Box 140-299 • Staten Island, NY 10314

If donating by Credit Card, please provide us with the following information :

Check your type of Credit Card : VISA Master Card American Express Discover

Credit Card Number: _____ Exp Date: _____

Name on the Card: _____

Please provide the following information in full:

Check Your Preferred Title: Ms Mrs Mr Dr None other _____

First Name: _____ Last Name: _____

Mailing Address: _____

City _____ State _____ Zip Code _____

Email _____ ☐ I do not want to receive email

Daytime Phone: _____ Evening Phone: _____

Authorized Signature _____ Date: _____