



# 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: \_\_\_\_\_