



INTERNATIONAL ASSOCIATION FOR HOSPICE & PALLIATIVE CARE

Promoting Hospice & Palliative Care Worldwide

DONATION FORM

The IAHPC is a 501(c)(3) Public Charity – This donation is tax deductible

Please note: IAHPC does not distribute or sell contact information of our donors. This information is treated as confidential and is only for our files and record keeping.

SECTION 1

***=Required Fields**

*Donor's Name: First: _____ Last: _____

*Address: _____

*City: _____ State/Prov: _____

*Country: _____ Postal Code: _____

*Email: _____ Phone (with area code): _____

SECTION 2

Please select the Program you wish the donation to be allocated to:

___ **General Funds:** Your donation will be allocated to pay for programs and operations based on need

___ **Traveling Fellowship Program:** Help send a professor to teach in a developing country

___ **Traveling Scholarship Program:** Help send a hospice/palliative care worker from a resource poor setting to learn and train in a program, seminar or congress

___ **Faculty Development Program:** Help support a teaching position for nurses and physicians in developing countries

SECTION 3

If this donation is made in memory of someone, please complete this section. If not, proceed to **SECTION 4**.

In Memory of: _____

If an acknowledgment of the donation is to be sent to a third party, please fill in the following:

Specify amount of donation in acknowledgment? Yes ___ No ___

Send letter of acknowledgment to:

Acknowledgment Name _____

Acknowledgment Address: _____

Acknowledgment City: _____ Acknowledgment State/Prov _____

Acknowledgment Country: _____ Acknowledgment Postal Code: _____

If you wish to include a phrase or statement in the acknowledgment letter, please write it below. IAHPC will copy your statement in the letter.

SECTION 4

*Amount of Donation To IAHPC:

Option 1 – One time donation of: \$_____ US Dollars only (no cents)

Option 2 – Ongoing donation of: \$_____ US Dollars only (no cents)

If Option 2, please specify: Monthly____ Quarterly____ Yearly_____

Donation made in US dollars using any of the following:

____ Check (in US dollars and payable to IAHPC)

____ Money order (in US dollars and payable to IAHPC)

____ Credit Card: (Choose one) Visa____ MasterCard____ American Express_____

*Name As Appears On Card:_____

*Account Number (No Spaces)_____

*Expiration Month____ Year:_____

*CVV_____

CVV number: For Visa/Mastercard, the three-digit CVV number is printed on the signature panel on the back of the card immediately after the card's account number. For American Express, the four-digit CVV number is printed on the front of the card above the card account number.

Cardholder's billing address is the same than SECTION 1? If not, please fill in the following:

*Cardholder's billing Address _____

*Cardholder's City _____

*Cardholder's State/Province _____

*Cardholder's Zip Code _____

*Cardholder's Country _____

*Cardholder's email address _____

*I agree to the amount stated in the total above be charged to my credit card (Print YES) _____

*Signature _____

Receipt required: YES_____ NO_____

Please send this completed form along with form of payment to:

IAHPC

5535 Memorial Dr.

Suite F - PMB 509

Houston TX 77007

USA

Or Fax To: +1 (713) 880-2948

If you have any questions about this donation, please contact us at admin@iahpc.com or call us toll free at (866) 374-2472

Thank you for your donation. We appreciate your support and help!

You will receive a confirmation letter once your donation is processed.

The IAHPC Team