



The Institute of Women's Health of North America
Improving Women's Health through Clinical Care, Research, Education, and Community Outreach™
PLEDGE/DONATION FORM

Name _____
Billing Address _____
Suite/Apt # _____
City _____
State _____
Zip _____
Phone (Main) _____ Phone (Other) _____
Fax _____

What area(s) would you like to donate for? (Please Check all that apply)

- Research
- Clinical Care
- Education
- Community Outreach
- Unsure

Which disease(s) would you would like to donate for?

- HIV/AIDS
- Sexually Transmitted Diseases
- Cervical Cancers
- Breast Cancers
- Family Planning
- Birth Control
- Other

If other, please specify: _____

Email Address: _____

I (we) pledge a total of \$ _____

- To be paid:
- Now
 - Quarterly
 - Monthly
 - Yearly

I would like to remain anonymous (please check)

Please Make Donation On Behalf Of: _____

Name (Print): _____ Signature _____

Date: _____

All donations/pledges must be mailed to the following address:
The Institute of Women's Health of North America
Attn: Chief Development Officer
Sand Lake Center
7380 Sand Lake Road, Suite 500
Orlando, FL 32819