

**MASSACHUSETTS MEDICAL SOCIETY AND ALLIANCE
CHARITABLE FOUNDATION**

Contribution Form

Fiscal Year June 1 through May 31

I/we would like to support the Massachusetts Medical Society and Alliance Charitable Foundation and its mission.

Donor Name: _____

Address: _____

City/State/Zip: _____

Home Phone: _____ Email: _____

Donor Recognition

- ☐ I authorize the Foundation to list my name as a contributor to the Foundation in the publications of the Foundation and its affiliates.

This is how I would like my/our names(s) to appear in all donor recognition listings for which I/we may qualify.

- ☐ I do not wish my/our name(s) to appear in donor listings.

Enclosed is my/our gift in the amount of:

- ☐ \$1,000 - Leadership Circle ☐ \$500 ☐ \$250 ☐ \$100 ☐ \$50 ☐ Other \$ _____

This gift is made:

- ☐ In memory of ☐ In honor of ☐ On the occasion of

Please Notify: _____

Payment Information

- ☐ Check #: _____ (payable to: MMS & Alliance Charitable Foundation)

- ☐ Credit Card #: _____ Exp. Date: _____
☐ AMEX ☐ Visa ☐ MasterCard

Signature: _____

Return this completed form to:

MMS and Alliance Charitable Foundation
860 Winter Street
Waltham, MA 02451

*Your gift is tax-deductible to the extent allowable by law.
Thank you for your generous support.*

The Foundation is a 501(c) (3) charitable organization. A written acknowledgement of your contribution will be provided to you.