# Contribution Form

**Fiscal Year: June 1 thru May 31**

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Donor Name:</td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>City/State/Zip:</td>
<td></td>
</tr>
<tr>
<td>Phone:</td>
<td></td>
</tr>
<tr>
<td>Email:</td>
<td></td>
</tr>
</tbody>
</table>

**Yes, I/we would like to support the Massachusetts Medical Society and Alliance Charitable Foundation and its mission. Enclosed is my/our tax-deductible contribution.**

- Visionary - $10,000 or more
- Leader (Leadership Circle) - $1,000 to $2,499
- Humanitarian - $5,000 to $9,999
- Patron - $500 to $999
- Benefactor - $2,500 to $4,999
- Friend – up to $499

**Payment/Pledge Information**

- Amount: $__________
- Check #:__________ (payable to: **MMS & Alliance Charitable Foundation**)

- Credit Card #: ___________ Exp. Date: _______
  - AMEX
  - Visa
  - MasterCard

**Donor Recognition**

- I/we authorize the Foundation to list my/our name as a contributor to the Foundation in the publications of the Foundation and its affiliates. I/we would like my/our name to appear in all donor recognition listings for which I/we may qualify, as follows:
  
  ____________________________________________

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

**This gift is made**

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

**Please notify**

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>City/State/Zip:</td>
<td></td>
</tr>
</tbody>
</table>

---

*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.*