Boston University Medical Campus
Alzheimer's Disease Clinical and Research Program
Donation Form

About Your Gift: **Date:_____**

This contribution is in support of the **Alzheimer's Disease Research Fund**

□ in Memory of _____
□ in Honor of _____
Person's name

Name and address of the person whom we should send a letter acknowledging the gift: _____
_____
_____

Can we mention this gift in our center's newsletter? Yes No

About You:

_____
First Name *Last Name*

_____
Address *Apt #*

_____
City *State* *Zip/Postal Code*

_____ _____
Telephone Number *Email Address*

About Your Payment:

Gift Amount $ _____

Method of Payment:

□ **Credit Card** *see below*

I authorize Boston University to collect my gift from a credit card account, as specified below (select one):

□ **Single Payment** of the total gift amount above
□ _____ **Equal Monthly Payments** starting in _____ / 2015 and ending in _____.

Credit Card Type (circle): Visa MasterCard American Express Discover

Credit Card Number: _____

Expiration Date: _____ / _____ Name on Card: _____

□ **Check** *Please make payable to:* **Trustees of Boston University** and enter fund #4089-3 in the memo section.

Please mail to: Ms. Lorraine Baldwin, Boston University School of Medicine, Alzheimer's Disease Center, 72 East Concord Street - Robinson 7800, Boston, MA 02118

For questions about your donation or this form, please call **Ms. Lorraine Baldwin at 617.414.1194**

Thank you! Your generous gift will help support our mission to fight Alzheimer's disease.