MARATHON SAN FRANCISCO 2008 DONATION FORM

MSF4: 3 AUGUST 2008

Participant Name: ______________________ **Participant Number:** ________

Thank you for your contribution in support of the San Francisco AIDS Foundation. Funds raised through the National AIDS Marathon Training Program will support the work of the San Francisco AIDS Foundation as well as Bay Area AIDS Prevention and Care Efforts and Treatment Access in the Developing World.

Please be as generous as you can. Contributions are tax-deductible to the full extent allowed by law.

PERSONAL INFORMATION *Fill in the following information. Please print legibly.*

First Name ☐ Ms. ☐ Mrs. ☐ Mr. ☐ Dr. M.I. Last Name

Additional Donor ☐ Ms. ☐ Mrs. ☐ Mr. ☐ Dr. M.I. Last Name

Company Name (For Corporate Donations Only) Country (if other than U.S.)

Mailing Address Suite/Apt. #

City State Zip

Phone Number ☐ Home ☐ Mobile ☐ Work Email

Donors will receive a letter of acknowledgement for tax purposes. ***Donations are fully tax deductible****.*

The Federal EIN for the San Francisco AIDS Foundation (SFAF) is 94-2927405.

DONATIONS *All contributions are non-refundable and non-transferable, regardless of participation in the AIDS Marathon.*

$10,000
☐ pay total
☐ 10 monthly payments of $1,000

$2,500
☐ pay total
☐ 10 monthly payments of $250

$1,000
☐ pay total
☐ 10 monthly payments of $100

$750
☐ pay total
☐ 10 monthly payments of $75

$500
☐ pay total
☐ 10 monthly payments of $50

$250
☐ pay total
☐ 10 monthly payments of $25

$150
☐ pay total
☐ 6 monthly payments of $25

Other:
☐ pay total of $ ______

☐ pay _____ monthly payments of

$ _____ totaling $ _______
(Monthly payments must be at least $25 and cannot exceed 10 months.)

CORPORATE MATCHING

Many businesses will match employee charitable donations. If your company will match your gift, please complete your paper or online application through your employer. The street address to mail forms (if required) is: ***San Francisco AIDS Foundation, 995 Market Street, Suite 200, San Francisco, CA 94103****. Matching funds will count toward your sponsored participant's fundraising requirement when received.*

PAYMENT OPTIONS *Please do not send cash.*

PERSONAL CHECK

☐ **Single Payment.** Please make checks payable to AIDS Marathon SF. Include participant's name and number on all checks.

CREDIT CARD

☐ **Single Payment.** Please debit a one-time payment of $ _______ from my credit card.

☐ **Direct Monthly Deductions From Credit Card.** Please debit my credit card $_______ automatically each month for ____ months, for a total contribution of $ ________. *(Monthly payments must be at least $25; not to exceed 10 months.)*
This authorization will expire when my contribution has been paid in full or when revoked by me in writing.

☐ Visa ☐ MC ☐ AmEx ☐ Discover Account Number ______ Exp MM / Exp YY

Signature ______________________________ Date ____________

Please mail this form with your donation to:

AIDS Marathon
c/o San Francisco
AIDS Foundation
995 Market Street, Suite 200
San Francisco, CA 94103

Questions?

Call the San Francisco AIDS Foundation Pledge Office:
(415) 487-3092

or e-mail:
development@sfaf.org

Please do not send cash.