



Rutland Regional Medical Center  
Marrow Donor Program

**Contribution Form – Account # 3209**

**NAME OF SUPPORTER:** \_\_\_\_\_

**CONTACT NAME:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**CITY:** \_\_\_\_\_

**TELEPHONE:** \_\_\_\_\_

<p><b>AMOUNT OF CONTRIBUTION:</b> _____</p> <p><b>PURPOSE OF CONTRIBUTION:</b> <u>To Pay for Tissue Testing</u></p> <p>_____</p>
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<b>FORM OF PAYMENT:</b>	
<input type="checkbox"/>	Please find enclosed a check payable to THE MARROW FOUNDATION.
<input type="checkbox"/>	Please contact my firm for _____ Name of Person to Contact _____ an electronic transfer of funds. Phone Number for Contact _____
<input type="checkbox"/>	Please accept this pledge payable on the following dates: _____ _____
<input type="checkbox"/>	Please send an invoice.
<input type="checkbox"/>	Alternative Method of Payment: _____

**NAME:** \_\_\_\_\_ **TITLE:** \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

Name as it should appear in publications of The Marrow Foundation and the National Marrow Donor Program:

\_\_\_\_\_

**Please complete this form and fax it with your signature to:**

<p>The Marrow Foundation NW 5837 P.O. Box 1450 Minneapolis, MN 55485-5837</p>
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