



EYE INSTITUTE GIVING FORM

I. Please accept my pledge/gift of \$_____ to support the Medical College of Wisconsin Eye Institute.

This gift is a tribute, in memory of: _____ in honor of: _____

Please send acknowledgement of this tribute to: Name: _____
Address: _____
City, State, Zip: _____

II. Please direct my gift to:

- Area of Greatest Need General Vision Research Retina Research Glaucoma Research
 Pediatric Ophthalmology Research Macular Degeneration Research Low Vision Clinic
 Advanced Ocular Imaging Program General Department Fund Resident Education
 Specific physician/researcher (please specify name) _____
 Other (please specify) _____

III. Donor Information:

* Please print your name(s) as you would like it to appear in the annual report:

I/We wish to remain anonymous

Address: _____

City, State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Email Address: _____

IV. Method of Payment:

CREDIT CARD Name on Card: _____

Card #: _____ Exp. Date: _____

Signature: _____

CHECK ENCLOSED (payable to the Medical College of Wisconsin)

PLEDGE payable at \$_____ per (month / quarter / year). Reminders will be sent.

STOCK TRANSFER

I have enclosed a completed matching gift form from my employer.

I have included the Eye Institute in my estate plans.

I would like information on how to include the Eye Institute in my estate plans.

Thank you for your support!

** Unless otherwise noted, all gifts over \$250 will be recognized in the Annual Report.*

Mail this form to: MCW Eye Institute, Attn: Office of Development, 8701 Watertown Plank Road, WI 53226.

For more information, please call (414) 955-4700.