

Please print, complete and mail this form to:

# Pulmonary Fibrosis

FOUNDATION

230 EAST OHIO STREET SUITE 500 CHICAGO, ILLINOIS 60611 844.TALKPFF | 844.825.5733 PHONE

866.587.9158 FAX

\$5,000     \$1,000     \$500     \$250     \$100     \$50     Other: \$ \_\_\_\_\_

One-time Donation     Recurring Monthly Pledge

Please make checks payable to the "Pulmonary Fibrosis Foundation" or "The PFF"

## Contact Information

Name/Company: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Please send me additional information about the Pulmonary Fibrosis Foundation.

## Primary Interest In Pulmonary Fibrosis

Patient     Caregiver     Lung Transplant Recipient     Physician     RN

Researcher     Allied Health Professional     Prefer not to say     Other \_\_\_\_\_

## Additional Gift Information (optional)

Tribute Information

General     In Memory     In Honor     Event

Tribute First and Last Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## Please Send Notification of my Gift to:

Name/Relationship to Tributee:

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**Payment Information**     Check     Credit Card     Other \_\_\_\_\_

Credit Card Information (if applicable): \_\_\_\_\_

Card Type: \_\_\_\_\_ Credit Card Number: \_\_\_\_\_

Date of Expiration: \_\_\_\_\_ Name as it appears on card: \_\_\_\_\_

## Billing Information (if different from above)

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Thank you for supporting the pulmonary fibrosis community!**

*The PFF is a 501(c)(3) nonprofit public benefit corporation and your contribution is tax deductible to the extent allowed by law.*

[www.pulmonaryfibrosis.org](http://www.pulmonaryfibrosis.org)