

I want to make a difference and support arthritis research!

CONTACT INFORMATION

NAME _____

ADDRESS _____

CITY _____ PROVINCE _____

POSTAL CODE _____

TELEPHONE _____

EMAIL _____

PREFERRED CONTACT: PHONE EMAIL MAIL

PLEASE ACCEPT MY GIFT OF:

ONE TIME: \$50 \$100 \$500 \$1,000 Other: _____

MONTHLY: \$ _____ per month

Please note monthly donations are withdrawn on the 1st of each month.

PAYMENT INFORMATION

Cheque enclosed, made payable to Arthritis Research Canada

Pre-authorized withdrawal (I have enclosed a void cheque).

Visa MasterCard AMEX

CARD NUMBER: _____

EXPIRY DATE: _____ CCV: _____

NAME: _____

SIGNATURE: _____

PREFERENCES

A gift of \$1,000 or more distinguishes you as a member of our Fellows Circle Giving Program.
Please share how you wish your name to appear for recognition purposes:

I wish to remain anonymous