

Yes, I would like to support EyeCare America

Donor Name (s) as it should appear on Honor Roll

Address

City, State, Zip

I prefer to remain anonymous

If paying by check:

Please make checks payable to **EyeCare America**

If paying by credit card:

Please charge my gift to the credit card listed below:

- MasterCard Visa JCB
 American Express Discover

Name on credit card (please print)

Cardholder's Billing Address

City, State, Zip

Card Number

Expiration Date

Signature

Please mail this form, along with your gift, to:

EyeCare America
P.O. Box 45568
San Francisco, CA 94145-9907

- \$2,500 Leadership Council
 \$1,000 Partners in Sight
 \$500
 \$250 \$50
 \$100 \$25
 Other: _____

Your gift will be used where it is most needed unless indicated otherwise:

- Seniors EyeCare Program
 Glaucoma EyeCare Program
 AMD EyeCare Program
 Diabetes EyeCare Program
 Children's EyeCare Program

My gift is a tribute

- in memory of in honor of

Name (please print)

Name and address of person you wish us to notify about your gift:

Name (please print)

Address

City, State, Zip

- Please send me information on how I can make a gift from my will or trust to EyeCare America.