



DONOR INFORMATION FORM

YES! I WOULD LIKE TO MAKE A GIFT TO SUPPORT WEILL CORNELL MEDICINE

PERSONAL INFORMATION

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

TELEPHONE _____

EMAIL: _____

PAYMENT INFORMATION

ENCLOSED is my check in the amount of \$ _____ made payable to WCMC

CREDIT CARD TYPE: Mastercard American Express Visa

NAME ON CREDIT CARD (PLEASE PRINT CLEARLY)

CREDIT CARD NUMBER

EXPIRATION DATE

AMOUNT \$ _____ Your gift of \$1,000 or more will qualify you for membership in *Partners in Medicine*, our recognition society for special friends of Weill Cornell Medicine.

IN HONOR OF
(NAME AND ADDRESS) _____

SPECIFIC DESIGNATION? _____

Thank You for Your Support!

Web Form

Please make checks payable to "WCMC" and send completed form to:
Weill Cornell Medicine | Office of External Affairs | P.O. Box 22497 | New York, NY 10087-2497