St Peter's Hospital
ALS Regional Center
Lewis Golub MDA/ALS Clinic
St Peter's Health Partners

19 Warehouse Row
Albany, NY 12205
(518) 525-1629

Contribution Form

Name(s): _____

Address: _____

Phone Number: _____

Email Address: _____

I/we would like to make a gift of $_____ in support of St. Peter's ALS Regional Center in the following manner:

❒ Check Enclosed ❒ MC/VISA/American Express (please circle one)

Card Number: _____ Expiration Date: _____

Signature: _____ Name on card: _____

Do you or your spouse work for a "matching gift company"? ❒ Yes ❒ No

If yes, please tell us the company's name:

_____

Please designate my gift:

❒ Where most needed ❒ Memorial Gift honoring a loved one
❒ Living tribute celebrating a joyous occasion

Name of Person to be honored: _____

Your thoughtful remembrance will be acknowledged…a special letter will be sent to the family you designate. The amount of your gift **will not** be disclosed.

Please send letter to: _____

Address: _____

_____

—Thank you for your thoughtful contribution.—