739 West Peachtree Street, NW
Suite 200
Atlanta, GA 30308-1137
404-266-2020

☐ Please accept my/our gift in support of your sight saving work.

☐ This is a memorial gift in honor of a special person(s). Please see information on next page.

☐ This is a tribute gift in honor of a special person(s). Please see information on next page.

My Information

Name ____

Address ____

City, State, Zip ____

Phone ____

Method of Payment

By Check I have enclosed my check for $__________________.

By Credit Card Please circle one: VISA MasterCard American Express Discover

Card Number ____

Expiration Date ______________________________ Amount $___________

Signature ____

Bill Me As Follows

Please bill me monthly Amount $ _____________________

Please bill me monthly for one year Amount $ _____________________

Beginning on this date ____

About the Honoree

Title	
Name	
Message	
Closing	

Thank you for your support. Please mail or fax both pages of the form to:

Prevent Blindness Georgia
729 West Peachtree Street, NW
Suite 200
Atlanta, GA 30308-1137

Fax - 404-266-0860