

# PLEDGE DONATION

## DONOR INFORMATION

Name \_\_\_\_\_ Total Pledge Amount: \$ \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Telephone \_\_\_\_\_

Social Security # (optional) \_\_\_\_\_

Payment information:  Bill me  
 Credit card:  Visa  MasterCard  
Card # \_\_\_\_\_ Expiration date \_\_\_\_\_

Payment cycle:  Monthly  Quarterly  Bi-annually

Direct my gift to:  Area of Greatest Need  Administration  Scholarship  Research

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Submission of, and your signature indicates permission for ADHA Institute staff and/or its agent(s) to bill or apply the payments as indicated above either by credit card or invoice.

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### INSTITUTE USE ONLY

### TRANSACTION INFORMATION

Transaction Date: \_\_\_\_\_

VISA  MASTERCARD

GIFT AMOUNT: \_\_\_\_\_

CREDIT CARD # \_\_\_\_\_ EXPIRATION DATE \_\_\_\_\_

AUTHORIZATION # \_\_\_\_\_

ADHA DEPOSIT ACCOUNT # \_\_\_\_\_

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APPEAL \_\_\_\_\_  
(insert code #)

FUND \_\_\_\_\_  
(insert code #)