

Thank you for supporting Children's National Hospital patients and families!

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## Donation Information

I would like to donate to the Race for Every Child

I expect a donation from this organization/individual: \_\_\_\_\_

## Where would you like to direct your gift?

Race Participant Page: \_\_\_\_\_

Race Team Page: \_\_\_\_\_

## Gift Amount

\$50      \$100      \$250      \$500      \$1,000      Other \_\_\_\_\_  
One Time      Recurring (# of months) \_\_\_\_\_

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## Donor Contact Information

Company Name: \_\_\_\_\_

Title: \_\_\_\_\_

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Address 1: \_\_\_\_\_

Address 2: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Country: \_\_\_\_\_

E-mail: \_\_\_\_\_

Phone: \_\_\_\_\_

Date of Birth\*: \_\_\_\_\_

## Payment Type

Check (payable to Children's National Hospital Foundation)

Credit Card (check one)

Visa      MasterCard      AmEx      Discover

Name on Card: \_\_\_\_\_

Card Number: \_\_\_\_\_

CVV Number: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

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

\*Why do we ask for this? As a policy, the Children's National Hospital Foundation works to limit communications to anyone under 18 years of age. Providing this information will permit us to better communicate with you, while respecting the privacy of our donors and their families.

## Send this form with your payment to:

Children's National Hospital Foundation  
Attn: Race for Every Child  
1 Inventa Place, 6th Floor, West  
Silver Spring, MD 20910

**Tax ID for Children's National  
Hospital Foundation:**  
52-1640402

