



Donor Information

Chapter Contact Name/Solicitor _____

Donor Name: _____

Home Address: _____

Telephone: _____ Mobile: _____

Facsimile _____ E-Mail: _____

Company Name: _____ **Title:** _____

Address: _____

Telephone: _____ Mobile: _____

Facsimile _____ E-Mail: _____

Enclosed is My Gift of: \$ _____ Check#: _____

Charge My Credit Card Card# _____

Amex Visa MasterCard Discover Expiration Date: _____

Name As It Appears On Credit Card _____

My employer has a *Corporate Matching Gifts Plan*, please contact:
(name) _____ (telephone) _____

If you would like a memorial or tribute card sent, please indicate below:

Name of Person (or Persons) Being Honored: _____

Memorial In Honor Other (please specify): _____

Please send card to: _____

Address: _____

Please make your tax deductible check payable to:

Lupus Foundation of America, New Jersey Chapter, Inc.
PO Box 1184 • 150 Morris Avenue, Suite 102 • Springfield, New Jersey 07081
Phone: (973) 379-3226 • Fax: (973) 379-1053

All information is confidential.