CancerCare® Co-Payment Assistance Foundation

Thank You For Supporting CancerCare's Co-Payment Foundation Fund

CANCER CHANGES EVERYTHING. CANCERCARE® CAN HELP.

Please print, complete, and mail this form with your check or credit card information to the following address: CancerCare National Office | 485 Madison Avenue, 10th Fl, New York, NY 10022 | 212-712-8400

First Name* _____ **Last Name*** _____

Address* _____

City* _____ **State/Province*** _____ **ZIP*** _____

Country _____ **Email*** _____

I am making a one time gift of (*select amount*):

☐ $50 ☐ $250 ☐ $1,000 ☐ Other $ _____

☐ $100 ☐ $500 ☐ $5,000

Specific Fund _____

Make check payable to CancerCare.
To make your gift by credit card, fill out the information below:

Name *(as it appears on card)* _____

Credit Card Number _____

Expiration Date *(MM/YY)* _____

Credit Card *(select one)*:

☐ MasterCard ☐ VISA ☐ American Express ☐ Discover

I authorize CancerCare to charge my credit card for the amount indicated above.

Signature _____ **Date** _____

This gift is: ☐ in honor of ☐ in memory of

Name _____

Send card to *(Name)* _____

Address _____

City _____ **State/Province** _____ **ZIP** _____

Country _____ **Email** _____

* Asterisks indicate required information.