National AIDS Marathon Training Program

Post Office Box 66258
Washington, DC 20035-6258

Phone: 202.543.2RUN
Fax: 202.332.5FAX

Email:
dcinfo@aidsmarathon.com
Web site:
www.aidsmarathon.com

Matching Gifts:
Many companies will match employee contributions. Check with your employer for specific guidelines.

IRS Information:
As per IRS regulations, your cancelled check or credit card statement will serve as your receipt for any donation of less than $250. For donations of $250 or more, Whitman-Walker Clinic will send written acknowledgement to the address you provide above.

Please note:
Contributions will be processed immediately upon receipt by the AIDS Marathon office. If injury or other unforeseen circumstances prevent the above named participant from completing the Marathon, your donation will nonetheless benefit the critically important AIDS services of Whitman-Walker Clinic. No refunds will be issued.

National AIDS Marathon® Training Program

donor form

If you prefer, you may donate on-line at aidsmarathon.com

Official Donor Form for STEPHEN CONLEY - 0094

Thank you for your contribution in support of Whitman-Walker Clinic, the leading provider of AIDS services in the metropolitan Washington D.C. area. Funds raised through the National AIDS Marathon Training Program will allow Whitman-Walker to provide advanced drug therapies, medical care, and other vital AIDS services — to help keep people alive until there's a cure. Please be as generous as you can. Contributions are tax-deductible to the full extent allowed by law.

1. DONOR INFORMATION

Name_____

Address_____ Suite/Apt. No _____

City_____ State _____ Zip Code _____

Home Phone_____ Work Phone _____

Email Address _____

❑ *Please check here if you do not wish to receive mailings from Whitman-Walker Clinic.*

2. AMOUNT OF YOUR CONTRIBUTION

❑ Number One Fan — $1000 ❑ Teammate — $500 ❑ Supporter — $100

❑ Coach — $750 ❑ Cheerleader — $250 ❑ Other — $_____

3. METHOD OF PAYMENT

CHECKING ACCOUNT *Indicate one-time or monthly payment*

Select one:

❑ **One-time**: Enclosed is my check or money order payable to: **AIDS Marathon—DC** for $ _____

— OR —

❑ **Monthly:** Please debit my bank account in the amount of $_____ each month for the next _____ months, for a total contribution of $ _____. *All monthly donations must be completed by March 1, 2003.*

Please enclose a voided check.

I authorize my bank to transfer the amount shown above from my checking account each month, for the period specified above, directly to Whitman-Walker Clinic. I understand that a record of each charge will be included in my monthly bank statement and will serve as my receipt. This authority will expire when my contribution has been paid in full or when revoked by me in writing. (Please enclose a voided check.)

_____
Authorized Signature of Account Holder Date

CREDIT CARD *Indicate one-time or monthly charge and complete credit card information*

Select one:

❑ **One-time**: Please charge my credit card for a one-time donation of $ _____

— OR —

❑ **Monthly:** Please charge my credit card in the amount of $_____ each month for the next _____ months, for a total contribution of $ _____. *All monthly donations must be completed by March 1, 2003.*

Type of Card: ❑ Visa ❑ MasterCard ❑ American Express ❑ Discover

Card No ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Exp. Date (mm/yy) ☐☐ / ☐☐

Your statement will read "Whitman-Walker Clinic."

_____
Authorized Signature of Card Holder Date

4. SUBMIT YOUR DONATION

Please send this form along with your payment to:

NATIONAL AIDS MARATHON TRAINING PROGRAM, Post Office Box 66258, Washington, DC 20035

Credit Card donations may be faxed to: **202.332.5FAX**, Attn: Accounting Department