APhA Foundation Donation Form

Date:_______________________________

First Name:_______________________________ Last Name:___________________________

Address:___________________________________ Apt or Suite #:_________________________

City:__________________________ State:________________ Zip:_____________________

Email:___________________________________ Phone:______________________________

Donation for:

□ Gift Amount:___________________ □ Pledge Amount:___________________

Recurring: □ Monthly □ Quarterly

Cash Credit Check

Account #:____ Exp. Date:_______________

CSV:_____________________ Check #:________________

Signature:____

Thank you for your recent gift of $______________to the APhA Foundation on _____________. Your gift supports our mission of ***improving people's health through pharmacists patient care services***.

The mission of the APhA Foundation is to improve health by inspiring philanthropy, research and innovation that advances pharmacists' patient care services. The APhA Foundation looks to create a new medication use system where patients, pharmacists, physicians and other health care professionals collaborate to dramatically improve the cost effectiveness and quality of patient health outcomes.

The APhA Foundation is a 501(c)(3) non-profit organization; EIN: 52-6039142.
Unless otherwise noted, no goods or services were provided to you in return for your contribution.
This is your receipt and should be kept with your tax records.