INTERNATIONAL WALDENSTROM'S MACROGLOBULINEMIA FOUNDATION
Donation Form

1.( ) I wish to make a **recurring** ( ) mthly ( ) qrtrly ( ) annual pledge of $_____for a total gift of $_____ continuing for the next_____years. (A max. of 5 years and a min. of $25 for the monthly pledge are suggested.)

Please allocate_____% Where needed;_____% to Member Services Fund;_____% to Research Fund.

( ) Please charge to the credit card shown below; ( ) My initial gift is enclosed.

Special Designation_____

2. ( ) I wish to make a **single gift** to IWMF in the amount of $_____.

Please allocate_____% where needed;_____% to Member Services Fund;_____% to Research Fund.

( ) Please charge to the credit card shown below; ( ) My gift is enclosed.

Special Designation_____

3.( ) I wish to transfer stock or property to the IWMF. Please contact me.

4.( ) I have or wish to provide for the IWMF in my estate plans. Please contact me.

5.( ) You may also designate your gift in honor or memory of another person by completing the information below.

I designate my member services and/or research pledge as a tribute:

in **honor** of_____or in **memory** of _____

Please notify: Name_____

Address: _____ _____

Street City State Zip

To make a single contribution or recurring pledge by credit card:

Name on credit card_____Type ( ) MC ( ) VISA ( ) AMEX ( ) DISCOVER

Credit card #_____Expiration date_____/_____

Do you wish to remain anonymous? ( ) No ( ) Yes

Name_____

Please list my/our name in publications as: _____

Address _____

Street City State Zip

Phone _____Email _____

Single gift or recurring pledge: Signature_____Date _____

If you have chosen the credit card option above, please be advised that your credit card will be charged when this form is received and in subsequent months, quarters or annually for the recurring pledge option.

Information and Contact Preferences

I am a: ❑ WM patient ❑ Caregiver ❑ Family member ❑ Physician ❑ Other Medical Professional

❑ Other (please specify) _____

❑ Subscribe me to IWMF eNEWS alerts about WM and IWMF activities (must opt in to IWMF emails on next page)

❑ US residents only – subscribe me to the printed copy of the Torch newsletter instead of the electronic version

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Contact Preferences:

Email:	❑ **Opt IN** to emails from the IWMF	❑ Opt OUT of emails from the IWMF
Phone:	❑ **Opt IN** to phone calls from the IWMF	❑ Opt OUT of phone calls from the IWMF
Postal Mail:	❑ **Opt IN** to postal mailings from the IWMF	❑ Opt OUT of postal mailings from the IWMF

OR ❑ *Please opt me out of ALL communications and permanently delete my personal data after processing my information.*

The following questions are optional and used ONLY for internal IWMF statistics

If you are a WM Patient -

Patient Gender: ❑ Female ❑ Male Year of Birth_____Year of Diagnosis_____

Privacy of visitors to IWMF's website www.iwmf.com and to all IWMF Members is of the highest concern to the IWMF. Please visit https://www.iwmf.com/privacy-policy to read the entire IWMF Privacy Policy. The IWMF is committed to your privacy and to providing you with the most accurate information possible.

Please return completed form to the IWMF Business Office:

6144 Clark Center
Avenue Sarasota, FL
34238, USA
Phone: 941-927-4963; Fax: 941-927-4467

For help or questions; contact Jeremy Dictor at jdictor@iwmf.com

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