



Print this page and fill it out, then mail or fax it to our office. We do not recommend emailing credit card information to us.

Name _____

Address _____

City, State Zip _____

Phone _____

Amount of donation _____

Select one I am making this donation by

- Check
- Credit card - Visa
- Credit card - MasterCard

For a credit card donation, the name, address, and phone given above must match the billing information for the credit card. Please fill out this additional information

Credit card number _____

Credit card expiration date _____

After filling out the form above, please mail it to

My Friends Care Bone Marrow Transplant Fund
148 S. Main Street, Suite 101
Mount Clemens, MI 48043

or FAX it to our office at 586.783.7404.