



My Friends Care Cancer Fund

Helping hands raising funds and hope

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Mount Clemens, MI 48040
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DONOR DRIVE REQUEST FOR ASSISTANCE FORM

Contact person name: _____ Date: _____

Organization or group name (if applicable): _____

Address: _____

City, State, Zip: _____

Phone: _____ FAX: _____ E-mail: _____

Is this drive being held on behalf of a specific person? _____ Yes _____ No

If yes, person's name: _____

Has a donor search been initiated? _____ Yes _____ No

If yes, describe results: _____

Have you contacted an NMDP Donor Center yet? _____ Yes _____ No

Which Donor Center are you working with? _____

What is the cost per test, quoted to you? _____

What is the date of your donor drive? _____

Location of drive: _____

How many people do you plan to test at this drive? _____

Are there any additional sources of funding available for testing at your drive?

_____ Yes _____ No If yes, please describe _____

Indicate below, which types of assistance your group would like:

_____ Information about how to host a donor drive.

_____ Suggestions for securing a location for the drive.

_____ Assistance with making arrangements for testing.

_____ Literature about bone marrow transplants and the National Marrow Donor Program for those attending the drive.

_____ Assistance with fund raising to pay for testing costs.

_____ A one time grant of funds to pay for testing. (Limit \$2,000.00 if funds are available or other arrangements are made with MFC)

Amount of funds requested: \$ _____