

# Donation Form

I/We commit to giving the Wisconsin Alliance for Women's Health a total gift of

\$ \_\_\_\_\_

Name: \_\_\_\_\_

Name as you wish to be recognized\*: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, ZIP: \_\_\_\_\_

Main Phone: \_\_\_\_\_

Contact Email: \_\_\_\_\_

\* I wish to remain anonymous

## Payment Type

Check

Visa/MC # \_\_\_\_\_ Exp. Date \_\_\_\_\_

## Mail or Fax to:

Wisconsin Alliance for Women's Health  
PO Box 1726  
Madison, WI 53701  
(608) 256-3004 fax

*Thank you for supporting women's health in Wisconsin!*

[www.supportwomenshealth.org](http://www.supportwomenshealth.org)