LIFE ALLIANCE
ORGAN RECOVERY AGENCY
UNIVERSITY OF MIAMI

CHARITABLE CONTRIBUTION

Helping Families, Saving Lives, Inspiring Our Community

I understand the need for organ, eye and tissue donation is urgent. Please accept this gift to help support donor families and inspire people to donate life.

Company Name/Individual:_____

Billing Address:_____

City:_____ State:_____ Zip:_____

Daytime Phone:_____ Email:_____

PAYMENT OPTIONS: ☐ I wish to remain anonymous

Check in the amount of $_____ Payable to: **Life Alliance Organ Recovery Agency**

Please charge my credit card in the amount of:_____

☐ Visa ☐ Master Card ☐ Discover ☐ American Express

Credit Card #:_____ Expiration Date:_____

Print name as it appears on the card:_____ CVV Code:_____

Cardholder's Signature:_____

Please direct my gift to: ☐ Donor Family Support Services ☐ Public Education Programs ☐ Other

_____

This gift is in the memory of a loved one, in honor of a recipient, or as a special acknowledgment.

In memory of:_____

In honor of:_____

☐ Optional A special acknowledgment of:_____

Please notify the following person(s) of my gift:

Name(s):_____

Address:_____

City:_____ State:_____ Zip _____

Please mail this form with the payment enclosed to the address below, Attn: Donor Family Services. If paying with a credit card, and would prefer to call us, please call (305) 243-5371. You may also contact us via email at dfager@med.miami.edu.

ALL DONATIONS ARE TAX DEDUCTIBLE
UNIVERSITY OF MIAMI TAX ID 59-0624458

Life Science and Technology Park
1951 N.W. 7th Avenue ▪ Suite #220 ▪ Miami, FL 33136 ▪ (800) 232-2892 ▪ (305) 243-7622