



**Parkinson's Institute
and Clinical Center**

**Yes! I want to provide compassionate care and advance research toward the
cure for those suffering from Parkinson's and related movement disorders.**

Please print and fill out this form and return it with your check to:

**Parkinson's Institute and Clinical Center
2500 Hospital Drive, Building 10 Suite 1
Mountain View, CA 94040**

Donation Information:

Gift Amount: \$50 \$100 \$250 \$500 \$1,000 Other _____

Mr. | Ms. | Mrs. | Dr. Name

Address

City State/Province Zip Country

Telephone Email

Payment Information:

- Check (Make checks payable to the Parkinson's Institute and Clinical Center)
- Visa MasterCard American Express Discover

Credit Card Number Expiration Date

Name on Card

Billing Address

City State/Province Zip Country

Signature

Tribute Gift Information:

When a gift is received in honor or memory of someone, the Parkinson's Institute Clinical Center will send an acknowledgment to the person or family indicated notifying them of your thoughtful contribution, but not revealing the amount of the donation.

This gift is in honor of or memory of (circle one) of _____

Please send an acknowledgment card on my behalf to:

Mr. / Ms. / Mrs. / Dr. Full Name

Address

City State/Province Zip Country

Questions? Call (650) 770 0201