



DONATION FORM

Participant Information:

Day of Giving Participant Name (if applicable): _____

Designation Area (select one):

- Most Pressing Needs
- Angel Fund
- Bladder Cancer
- Brain Cancer
- Breast Cancer
- Clinical Trials Unit
- Colorectal Cancer
- Esophageal Cancer
- Genetics Testing
- Gynecological Cancer
- Immunotherapy
- Leukemia
- Liver and Pancreas Cancer
- Lung Cancer
- Lymphoma
- Melanoma
- Myeloma
- Pediatrics
- Prostate Cancer
- Renal Cell & Kidney Cancer
- Sarcoma
- Skin Cancer
- Stomach Cancer
- Supportive & Palliative Care
- Thyroid and Head & Neck Cancer Clinic
- Transplant & Cellular Therapy Unit

Donor Information:

Name: _____

Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____ Phone: _____

Donation Amount: *Please make checks payable to Roswell Park Alliance Foundation and include the designation area you wish to support in the memo field.*

Total Check Dollar Amount: \$ _____

Thank you for your contribution!
Please mail this form and your check(s) to:

**Roswell Park Alliance Foundation
P.O. Box 644
Buffalo, NY 14240-0644**

Questions?
Email: giving@roswellpark.org
Phone: 716-845-8788