



I would like my gift to benefit:

- | | |
|-----------------------------------------------------------------------------|----------------------------------------------------------------------------------|
| <input type="checkbox"/> William C. Allen, MD, Endowed Professor 160712 | <input type="checkbox"/> Global Health Training Fund 120282 |
| <input type="checkbox"/> Armstrong-Carmichael Resident Ed. Endow. 301972 | <input type="checkbox"/> Roger W. Hofmeister, MD, Resident Ed. Endow. 219472 |
| <input type="checkbox"/> A. Sherwood Baker, MD, Resident Ed. Endow. 219482 | <input type="checkbox"/> David Oliver Fam. and Comm. Med. Faculty Award 219452 |
| <input type="checkbox"/> Robert L. Blake Jr, MD, Endow. for Med. Ed. 300052 | <input type="checkbox"/> Gerald T. Perkoff, MD, Lectureship Endow. 219492 |
| <input type="checkbox"/> Jack M. and Winifred S. Colwill Endow. 210392 | <input type="checkbox"/> Paul Revare, MD, Family Professor of Family Med. 213322 |
| <input type="checkbox"/> Future of Family Medicine Professor 214602 | <input type="checkbox"/> Theodore S. Wittels, MD, Memorial Fund 303422 |

How I would like to donate:

Single Contribution

I/we wish to make a gift of:

☐ \$100 ☐ \$250 ☐ \$500 ☐ \$1,000 ☐ Other \$ _____

Recurring Gift

- ☐ I/we pledge to make our gift in equal installments of \$ _____ beginning in _____
(month/year) for a total amount of \$ _____.
- ☐ I/we intend to make payments: ☐ Monthly ☐ Quarterly ☐ Annually

Signature _____ Print Name _____

Pledge Reminder

- ☐ I would like to receive pledge reminders when my payment is due.

Giving information

- ☐ My check, payable to the University of Missouri, is enclosed.
- ☐ Please charge my credit card: ☐ Visa ☐ MasterCard ☐ Discover ☐ AMEX

CARD NUMBER _____ EXPIRATION DATE _____ CVV _____
(CVV for recurring gifts only)

SIGNATURE _____ PRINT NAME _____

(AS IT APPEARS ON YOUR CARD)

ADDRESS _____ DAYTIME PHONE _____

Gifts are tax-deductible to the fullest extent allowed by law.

Help us say thank you

Your gift may qualify you for membership in one of the university's recognition societies.

- ☐ I/we prefer my/our name(s) to be confidential.
- ☐ I/we would like information on membership in the Columns Society, Jefferson Club, or McAlester Society.
- ☐ I/we wish my/our name(s) to read as follows on honor rolls: (PLEASE PRINT)

NAME(S) _____

Please return this form to:

SCHOOL OF MEDICINE ADVANCEMENT
ONE HOSPITAL DRIVE, DC205.00
COLUMBIA, MO 65212

Thank you for your support.

PHONE: 573-882-6100
TOLL FREE: 866-260-4517
SCHOOLOFMEDICINEDEV@MISSOURI.EDU