



Name \_\_\_\_\_

Email \_\_\_\_\_ Phone Number \_\_\_\_\_

**I would like my gift to benefit:**

- Medical School Dean's Fund for Excellence C8353 | 121132
- Medical School Scholarship Fund C8405 | 120062
- Other \_\_\_\_\_

**How I would like to donate:**

**Single Contribution**

I/we wish to make a gift of:

- \$2,500
- \$1,000
- \$500
- \$250
- 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.*

**Please Return this form to:**

School of Medicine Advancement  
One Hospital Drive, DC 205.00  
Columbia, MO 65212

**Thank you for your support!**

Phone: 573-882-6100  
Toll Free: 866-260-4517  
[schoolofmedicinedev@missouri.edu](mailto:schoolofmedicinedev@missouri.edu)