



DONATION FORM

Name _____

Address _____

City _____

State _____

Zip _____

Phone _____

Email _____

Gift Amount: \$ _____

Recurring: To be paid once a month on the ____ first of the month or the ____ 15th of the month.

One time gift

Please select where you would like to designate your gift:

Students First Fund

Athletics:

General Athletics

Specific Athletics: _____

Scholarships:

General Scholarship Fund

Specific Scholarship Fund: _____

Discovery for Life:

Student Experience

Center for Biopharmaceutical Education and Training

Campus Master Plan

Other: _____

This gift is in honor/memory of _____

Preferred Payment Method

Credit Card (Name, Number, Exp. Date, CCV):

Check: Made out to Albany College of Pharmacy and Health Sciences

Stock

Other _____