



DONATION CHECK FORM

PLEASE SEND DONATIONS MADE BY CHECK ALONG WITH THIS FORM TO: Rise of Broken Women, 601 West 26th Street, Suite 325-264, New York, NY 10001

Donation amount \$ _____

☐ **Yes! I would like to make a recurring donation to support an individual in need of monthly feminine hygiene.**

- ☐ \$18 Sponsors one woman for one month
☐ \$36 Sponsors one woman for two months
☐ \$108 Sponsors one woman care for three months

- ☐ \$600 Sponsors one-quarter of care to women shelter
☐ \$1,200 Sponsors two-quarters of care to women shelter
☐ Other \$ _____ / month

DONOR INFORMATION*

PLEASE PRINT CLEARLY

First Name _____

Last Name _____

Company (Optional) _____

Address _____ Apt./Suite _____

City _____ State _____ Zip _____ Phone (____) _____ - _____

Email _____@_____

TO MAKE YOUR GIFT IN HONOR OF OR IN MEMORY OF AN INDIVIDUAL OR FAMILY MEMBER, PLEASE COMPLETE THE FOLLOWING SECTION:

Please note, the Rise of Broken Women does not disclose the donation amount.

I would like my gift to be (select one):

☐ In honor of

☐ In memory of Honoree

Please send acknowledgement of my donation to: PLEASE PRINT CLEARLY

First Name _____ Last Name _____

Address _____ Apt./Suite _____

City State _____ Zip Code _____