Pledge Form

American International Health Alliance

Building sustainable health systems and workforce development through locally-driven, peer-to-peer institutional partnerships world wide

Donor Information (please print or type)

Name _____

Billing address _____

City, State, Zip Code _____

Phone 1 | Phone 2 _____

Fax | Email _____

Pledge Information

I (we) pledge a total of $_____ to be paid: ☐now ☐quarterly ☐date specified _____

I (we) plan to make this contribution in the form of: ☐cash ☐check ☐credit card ☐other.

Credit card type | Exp. date _____

Credit card number _____

Authorized signature _____

Gift will be matched by (company/family/foundation)

☐form enclosed☐form will be forwarded

Acknowledgement Information

Please use the following name(s) in all acknowledgements:

☐I (we) wish to have our gift remain anonymous.

_____

Signature(s) Date

Please make checks, corporate matches, or other gifts payable to:

American International Health Alliance
5614 Connecticut Avenue,NW, #293
Washington, DC 20015-2604