



Please Accept

my donation of:

- \$50
- \$100
- \$250
- \$500
- \$1,000
- \$2,500
- \$5,000
- Other \$ _____

To be paid:

- Annually
- Semi-Annually
- Quarterly
- Monthly

Please charge my:

- AMEX
- MasterCard
- Visa

Card Number Expires Security code

Name as it appears on card (please print)

Address

City State Zip Code

Email Telephone day evening

- I am printing this form and mailing a check (please make your check to “The Discovery Eye Foundation for NKCF”)
- I work for a matching gift organization _____ and will mail this form

**Mail to: The National Keratoconus Foundation
6222 Wilshire Blvd., Suite 260
Los Angeles, CA 90048**

Please send me more:

- Information on including The National Keratoconus Foundation in my estate plan
- Information on Keratoconus
- Information on The National Keratoconus Foundation
- Information on The Discovery Eye Foundation

To learn more about a specific project or for more information, please email Catherine Warren at info@NKCF.org or call 310-623-4466.



TRIBUTE

This gift is: in honor of in memory of in appreciation of

Name (please print)

Address

City

State

Zip Code

Text for tribute

From