AMERICAN JEWISH MEDICAL ASSOCIATION

Pledge Form

Donor's Name: _____

Address: _____

Phone: _____ E-Mail: _____

Signature: _____ Date: _____

Donation

I pledge to contribute a sum of $ _____ according to the following payment plan:

- ___ One-time contribution of $ _____
- ___ Multiple contributions of $ _____
    - ___ Monthly
    - ___ Quarterly
    - ___ Annually
    - ___ Other

Payment

I would like to pay by:

- ___ Check attached

  All checks should be made payable to "American Jewish Medical Association."
  Please mail checks to the following address: PO Box 2157 Fairfax, VA 22031
- ___ I will make the payment on the AJMA website *theajma.org* by the following date: _____
- ___ Other

Once we receive your donation, we will send a confirmation email and receipt for your records.

Please scan and email this form to info@theajma.org or mail to:
American Jewish Medical Association,
P.O. Box 2157 Fairfax, VA 22031