2019 DONATION FORM

I would like to make a donation in the amount of: $_______________

If you would like your donation to be allocated to a specific individual or team, please include their info below:

Team Name: ________________________________

-or-

Participant Name: ____________________________

Donor Information (necessary for tax receipt):

Full Name:____

Address:____ City ________________ State ______ Zip __________

Email:____ Phone:___________________

Payment Information:

Please Check One:

☐Check *(payable to SBCW)* ☐Cash ☐Credit *(Amex, Visa, MasterCard, Discover)*

Card # ____ Exp Date_______ CVC #_________

Signature ____ Date_______________

Please mail completed form to:
Swedish Medical Center Foundation
Attn: Seattle Brain Cancer Walk
747 Broadway
Seattle, WA 98122

Seattle Brain Cancer Walk Customer Service
206.386.3445
Seattlebraincancerwalk@swedish.org