



2020 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