



**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 Credit
my donation to:**

- Treatment Accelerator Program Macular Degeneration
 DEF Keratoconus Glaucoma Children Eye Cancer

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
 I work for a matching gift organization _____ and will mail this form

**Mail to: The Discovery Eye Foundation
8635 W 3rd St
#390W
Los Angeles, CA 90048**

Please send me more:

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