



I would like to make a general donation to the event

I would like to make a donation to a participant  
*Participant Name:* \_\_\_\_\_

I would like to make a donation to a team  
*Team Name:* \_\_\_\_\_

Every dollar you contribute to Phoenix Children's Hospital has a direct impact on our children and their families. Your generosity makes it possible for us to offer the very best medical specialists, cutting-edge technology, and family-friendly services to our community. Thank you for investing in Phoenix Children's Hospital's life-saving work! If you have any questions, please call the Foundation office at (602)933-4483 to speak to a member of our team.

Please complete, enclose with your payment, and send to:

**PCH 5K**  
**Phoenix Children's Hospital Foundation**  
**2929 E. Camelback Rd. Suite 122**  
**Phoenix, AZ 85016**

Select gift amount:

\_\_\_\_\_ \$25 \_\_\_\_\_ \$50 \_\_\_\_\_ \$100 \_\_\_\_\_ \$250 \_\_\_\_\_ \$500 \_\_\_\_\_ Other (Please indicate amount \$\_\_\_\_\_)

**Donor Information:**

Title: \_\_\_\_\_

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Address 1: \_\_\_\_\_

Address 2: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Email: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**Payment Information:**

\_\_\_\_\_ Check (payable to Phoenix Children's Hospital Foundation)

\_\_\_\_\_ Credit Card

Visa  American Express  Discover  Mastercard

Card Number: \_\_\_\_\_

CSC #: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

Name on card: \_\_\_\_\_

Signature: (must be hand-signed in order to process payment)

\_\_\_\_\_