

## South Carolina HIV/AIDS Council

# \$15 for 15 month for 15 years - Pledge Form

### Donor Information (please print or type)

Name	
Address	
City/State/Zip	
Telephone (home)	
Telephone (business/Cell)	
E-Mail	

### Pledge Information

I (we) pledge a total of \$15. for 15 months to be paid:

now (\$225 total)

monthly (\$15. per month for 15 months)

quarterly (\$45. every three months for 5 months)

I (we) plan to make this contribution in the form of:

Payroll Deduction

Name of Employer: \_\_\_\_\_

Contact: \_\_\_\_\_ Phone \_\_\_\_\_

Check. *Please make checks payable to: SCHAC, 1115 Calhoun St, Columbia, SC 29201*

Credit/Debit Card

Cardholders Name	
Credit card number	
Expiration date	
Billing Address (if different)	

Gift will be matched by \_\_\_\_\_ (*company/family/foundation*).

form attached  form will be forwarded

### Acknowledgement Information

Please use the following name(s) in all acknowledgements:

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I (we) wish to have our gift remain anonymous.

Signature(s)	Date
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