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# DONATION FORM – Regenerative Medicine

*Yes, I will give a tax-Deductable gift.*

**PERSONAL DETAILS** (for receipt purposes)

Title: ☐ Miss ☐ Ms ☐ Mrs ☐ Mr ☐ Dr ☐ Prof ☐ Other .....

First Name: ..... Last Name: .....

Address: .....

Town/Suburb: ..... State: ..... Postcode: .....

Phone (BH): ..... Phone (AH): .....

Fax: ..... Mobile: .....

Email: .....

How did you hear about Kolling? .....

**DONATION DETAIL**

Gift amount: $ .....

Donate to: ☐ **Area of greatest need**, OR

☐ **Other (please specify): .....**

☐ **OPTION 1 – CHEQUE:** Please make payable to: **Kolling Foundation**

☐ **OPTION 2 - CREDIT CARD**

I authorise Kolling Foundation to charge the above mentioned amount to my credit card.

Credit Card Type: ☐ Visa ☐ Mastercard ☐ Amercian Express

Credit Card Number: ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ CCV No.: .....

Name on Card: ..... Expiry Date: ..... / ..... / .....

Signature: ..... Date: .....

☐ **OPTION 3 - DIRECT DEBIT**

I/We authorise Kolling Foundation to debit the above mentioned amount from my/our account at:

Financial Institution: .....

BSB: ☐☐☐ ☐☐☐ Account number: ☐☐☐☐☐☐☐☐☐

Account Name: .....

Signature: ..... Date: .....

Signature: ..... Date: .....

**PRIVACY STATEMENT**

The information provided by you will only be used for the purpose of giving you information about Kolling.

☐ Tick if you do not want to receive information about the work of Kolling.