Circle of Friends

Monthly Benefactors

Brain Injury Association of New York State

Yes, I want to join the Brain Injury Association of New York State's *Circle of Friends* to help sustain the circle of support around New York's brain injury community.

Name: _____

Address: _____

City, State and Zip: _____

Phone: _____ Cell Phone: _____

Email: _____

Name as you would like it to appear in print: _____

☐ I wish to remain anonymous.

Please make my gift: *In Honor of:* _____

In Memory of: _____

The Brain Injury Association of New York State never distributes donor addresses, email or phone numbers.

Monthly Donation Amount: ☐ $30 ☐ Other: _____

Please charge my:

☐ Credit Card

Cardholder Name: _____

Card Number: _____

CVV: _____ Expiration Date: _____ Zip Code: _____

☐ Checking Account

Account Holder Name: _____

Bank Name: _____

Account Number: _____

Routing Number: _____

By completing this form, I authorize the Brain Injury Association of New York State to charge my credit card or transfer from my checking account, monthly, the amount indicated above. This shall remain in effect until I request for the cancellation or termination.

I also certify that I am an authorized user on the account listed.

_____ _____

Signature Date

Please return this completed form to BIANYS, 4 Pine West Plaza, Suite 402 – Albany, NY 12205

Thank you for your support!