Sonoma County Medical Association Alliance Foundation

Physician families committed to creating a healthier Sonoma County
by improving the lives of those in need

Donation Form

Submit this completed form with your check or credit card payment information to:
SCMAA Foundation, P.O. Box 1388, Santa Rosa, CA 95402
(We are a 501(c)(3) charitable organization. Tax ID# 02-0542304)

DONOR NAME(S) *(as you would like it to appear in acknowledgments)*	DONATION AMOUNT $

SPONSORSHIP LEVELS for HEALTH CAREERS SCHOLARSHIP:
$75 $100 $250 **$500 *** **$1000 *** **(Circle of Champions Level)**
**Attend the Summer Scholarship Luncheon with your donation of $500 or more.*

DAY/WORK PHONE	CELL PHONE		
ADDRESS	CITY	ST	ZIP
EMAIL ADDRESS			

I will be making my gift: ☐ in honor of: ☐ in memory of:

PROGRAM DESIGNATION

_____ **Foster Children's Give-a-Gift Program**
This program has provided hundreds of children in our county's foster care system with holiday gifts. Laptop computers are also being purchased for college-bound foster youth.

✔ **Health Careers Scholarship** (SCMA & SCMAA Health Careers Scholarship)
This scholarship assists students who are pursuing health or health-related careers.

Health Promotions:

_____ **Children's Museum of Sonoma County Health & Science Lab**
In partnership with the museum, the Alliance supports the presentation of health information to visitors of the museum.

_____ **JourneySafe**
This program presents our county's high school students with an assembly about distracted driving.

_____ **Safe Schools Program**
This program allows for research-based anti-bullying and anti-violence curriculum to be purchased by teachers and counselors in our county.

_____ **SCMAA Foundation Endowment**
Contributions to the endowment ensure the initiation of new programs and functioning of current programs into the future.

PAYMENT INFORMATION: ☐ I would like this gift to be anonymous. Please do not publicly list my name on a donor list.

☐ **CHECK:** Please make check payable to **SCMAAF** ☐ **CREDIT CARD:** Mastercard VISA (Circle one)

NAME ON CARD	CREDIT CARD NOS	EXP DATE	CVV

BILLING ADDRESS (☐Check if Billing address is same as Address above)	CITY	ST	ZIP