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Donation Form

_____ I have enclosed a one-time donation of \$_____ by check, made payable to Shared Pregnancy.

_____ I would like my one-time donation of \$_____ to be charged to my credit card.

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Credit Card #: _____ Expiration Date: _____

_____ I want to be a monthly donor.

_____ I will send in a monthly check for \$_____.

_____ I would like my credit card charged monthly for \$_____

starting _____ and ending _____
Date Date

(Fill out the credit card information above).

My donation is given in: Honor _____ Memorial _____
of _____

Please send a card of recognition to:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Shared Pregnancy is a 501(c)3 nonprofit organization and all donations are tax deductible!

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