



# Giving to the Department of Surgery

\*=required fields

Please Select Recipient: \*

Gift amount: \* \_\_\_\_\_ other \$ \_\_\_\_\_

Dr. Miss Mr. Mrs. Ms.

Name: \* \_\_\_\_\_

### Joint gift with spouse

Spouse's name: \_\_\_\_\_

Home Business (company name required) \_\_\_\_\_

Address: \* \_\_\_\_\_

City: \* \_\_\_\_\_ State \* \_\_\_\_\_ Zip Code \* \_\_\_\_\_

Home Phone: \* \_\_\_\_\_ Email: \_\_\_\_\_

Special instructions for this gift: \_\_\_\_\_

This gift is In honor of In memory of

Name: \_\_\_\_\_

### Please send acknowledgement of this gift to:

Dr. Miss Mr. Mrs. Ms.

First name: \_\_\_\_\_ Last name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Please select: \* **Check** – Enclosed is my check in the amount of \$ \_\_\_\_\_ made payable to **UC Regents**

**Charge** \$ \_\_\_\_\_ to my VISA MasterCard American Express Discover

Credit Card Number: \_\_\_\_\_

Name on Card: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Add me to the Department of Surgery mailing list

**\*\*Please fill out the form in full then print out and mail to:**

Office of Health Sciences Development  
4900 Broadway, Suite 1150  
Sacramento, CA 95820



The 1977 California Information Practices Act requires UC Davis to provide the following information to individuals asked to supply information about themselves: UC Davis is requesting this information to maintain accurate donor files in the Office of Development and Alumni Relations. Furnishing the information is strictly voluntary and it will be maintained confidentially. The information may be used by other university departments in the regular course of business but will not be disseminated to others except if required by law. You have the right to review your own data file. Inquiries should be forwarded to the Director of Advancement Services, University of California, Davis 202 Cousteau Place, Suite 185 Davis, CA 95618