New York State Academy of Family Physicians Foundation
Mission Statement
To Improve the health of New Yorkers through the activities of Family Physicians

Please Consider an Investment in the Future of Family Medicine

The New York State Academy of Family Physicians Foundation is committed to 1) enhancing the delivery of health care to the people of New York through the advancement of Family Medicine in research, education, student and resident leadership development, and health care delivery; 2) promoting the continued development of Family Medicine; and 3) supporting the philanthropic projects of the New York State Academy of Family Physicians. The Foundation supports preceptorships in Family Medicine for medical students, research projects and charitable and community service efforts by Family Physicians. If you would like to make a gift to support the work of the NYSAFP Foundation, please complete the form below and return it with your donation to:

NYSAFP Foundation
260 Osborne Rd.
Loudonville, New York 12211

_____ I _____ My spouse and I _____ My practice/company

would like to invest in the future of Family Medicine with the enclosed gift of $_____ to the New York State Academy of Family Physicians Foundation.

Name: _____
(Please indicate how you would like your name listed in our records.)

Address: _____
_____
Phone: ( )_____ Fax: ( )_____

Annual Fund Giving Clubs:

____	***Founders Club*** ***$2,500***	**____**	***Benefactors*** ***$250***
____	***Presidents Club*** ***$1,000***	**____**	***Sponsors*** ***$100***
____	***Patrons*** ***$500***	**____**	***Friends*** ***$99 or less***

_____ Please accept my enclosed check for the full amount
_____ Please send me an invoice each month for 10 months at the above address
_____ Please invoice me as follows: _____

I have already included ___ the AAFP Foundation ___ the NYSAFP Foundation in my will.
___ I would like information on including ___ the AAFP Foundation ___ the NYSAFP Foundation in my will.

Please direct my contribution to the following:
_____ Share with the AAFP Foundation as an unrestricted gift.
_____ Restrict for the purpose of: _____
_____ Restrict for the NYSAFP Foundation where the need is greatest.
_____ In memory/honor of: _____

<u>Please charge my gift to:</u> _____ AmEx _____ VISA _____ MasterCard

Card Number: _____ Exp. Date: _____ CVV_____

Name of cardholder: _____ Signature _____