

Help Improve the Lives of People with Interstitial Cystitis

Establish a recurring gift

For as little as 33¢ per day you can establish a recurring gift—and make a difference in the lives of people with interstitial cystitis (IC).

Giving a regular monthly donation fuels the ICA's ongoing work in research, education, support, and advocacy throughout the year. These monthly gifts add up and allow us to be confident in our abilities to continue with vital programs such as providing personal responses to thousands of emails and phone calls from people with IC; funding pilot research; educating healthcare providers about the unique needs of people with IC; advocating on Capital Hill on behalf of IC patients, healthcare providers, and researchers; and getting the word out about IC.

Sign up for a monthly donation and

- Receive special recognition in the *ICA Update*
- Encourage others to do the same through your commitment
- Continue to enjoy the benefits of the ICA annual membership, including a subscription to the ICA's quarterly magazine, *ICA Update*; monthly electronic news digest, *Cafe ICA*; email blasts about happenings in the IC community; and discounts on resource materials.

Enroll today! Sign up online at www.ichelp.org. Or, complete the form and mail it or fax it to the ICA.

- Mail to ICA, P.O. Box 17522, Baltimore, MD 21298-7036
- Fax to 301-610-5308

Over a year's time...

\$10 PER MONTH (33¢ per day)

- Provides 5 patient education kits
- Covers the cost of 4 healthcare provider education kits
- Sends out 1 blast email with the latest IC news to thousands of patients, healthcare providers, and researchers
- Contributes to the costs of promoting the healthcare reform needs of people with IC with policy makers

\$20 PER MONTH

- Allows the ICA to provide email support to 50 patients
- Helps pay for part of 1 regional forum, offering patients the opportunity to hear from IC experts and network with others
- Supports the costs of participating in 1 research meeting at the National Institutes of Health
- Helps ICA advocacy staff bring the message to policy and law makers

\$50 PER MONTH

- Provides 1 week of service of the ICA's "live operator" toll-free hotline, serving over 100 patients per week
- Supports the cost of 1 issue of the online version of *Professional Perspectives*, keeping thousands of healthcare providers abreast of the latest treatment and research news
- Helps the ICA exhibit at 1 professional meeting to educate doctors and nurse about the unique needs of IC patients

\$100 PER MONTH

- Pays for some of the costs for preparing articles for the *ICA Update*—on topics such as diet, alternative therapies, research updates, and personal stories about people conquering IC
- Educates 40 healthcare providers about IC treatments and research
- Pays for 3 month's worth of the *Healthcare Provider Registry*, matching patients with knowledgeable IC providers
- Assists us with ongoing Capitol Hill lobbying efforts to support IC research

Monthly Giving Authorization

I AUTHORIZE MONTHLY PAYMENTS OF

\$10 \$20 \$50 \$60 \$100 \$500 Other \$_____

To cover processing costs, recurring donation levels start at \$10 per month. Check one of the standard amounts suggested above. Or, authorize any amount you like on the "other" line starting from \$10 or more per month.

Name _____ Phone _____

Address _____

E-mail _____

MONTHLY WITHDRAWALS FROM CHECKING OR SAVINGS ACCOUNTS—Authorization agreement for direct payments (ACH Debits)

I hereby authorize the Interstitial Cystitis Association to initiate a monthly debit of \$_____ beginning the 15th of (month) _____ of (year) _____ to my account indicated below and to debit the same account. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of US law.

Financial Institution Name (your bank) _____ Financial Institution Address _____ City, State, Zip _____

Branch _____ *Depository Routing and Transit Number _____ *Customer Account Number _____

Please circle type of account: CHECKING SAVINGS

This authority is to remain in full force and effect until the Interstitial Cystitis Association or Depository has received a written notification from me 30 days in advance of its termination. I also recognize that I must notify the Interstitial Cystitis Association of any change in banks or accounts to ensure proper and timely deposit to my account 30 days prior to agreed upon monthly transaction date.

Customer Name _____ Signature _____ Date _____

***Please attach a voided copy of your personal check to this authorization form—this check identifies the routing transit number and your account number.**

MONTHLY CONTRIBUTIONS FROM CREDIT CARDS

Card Type: Visa MasterCard Discover American Express

Name of Cardholder _____

Card Number _____

Expiration Date Month _____ Year _____ Security Code _____

Signature _____ Today's Date _____

***Please let us know when your credit card expiration date changes or if you change your credit card. Thank you!**

MAIL THIS FORM TO: ICA, P.O. BOX 17522, BALTIMORE, MD 21298-7036. OR, FAX TO: 301-610-5308.

Interstitial Cystitis Association
www.ichelp.org
800-HELP ICA (800-435-7422)
ICAmail@ichelp.org

