

Registrant's Name: \_\_\_\_\_

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

City, State, ZIP: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_

In honor & partnership with: \_\_\_\_\_

I **accept / decline** to participate in an IFOPA rewards program, to earn retail gift certificates of up to 10% of total donations submitted to the IFOPA by May 31<sup>st</sup>, 2008. We appreciate your efforts to raise support and awareness for FOP. Thank You!

# STRIDE TO CURE FOP

*FIBRODYSPLASIA OSSIFICANS PROGRESSIVA*

**Saturday, May 10<sup>th</sup>**



Donor's Name	Complete Mailing Address (for IFOPA purposes only)	Phone	Matching Gift Program*	Donation
			Yes* / No	
			Yes* / No	
			Yes* / No	
			Yes* / No	
			Yes* / No	
			Yes* / No	
			Yes* / No	
			Yes* / No	
			Yes* / No	
			Yes* / No	
			Yes* / No	
			Yes* / No	
			Yes* / No	
			Yes* / No	
			Yes* / No	
<b>We kindly request a minimum TOTAL of \$50 per registrant (or \$150 per family), be submitted to the IFOPA by <u>Saturday, May 31<sup>st</sup>, 2008.</u></b>			<b>TOTAL =</b>	

\*If your employer has a Matching Gifts Program, please submit your company's Matching Gifts' form along with your donation. We thank you and your employer both! Contributions to the IFOPA are tax-deductible, to the extent allowed by law. The IFOPA is a 501(c)3; EIN #: 59-2918100. For further details, visit [www.ifopa.org](http://www.ifopa.org) or call 407.365.4194.

**Make checks payable to the IFOPA.** Please mail all donations and any Matching Gifts' forms to the IFOPA by **Saturday, May 31<sup>st</sup>, 2008.**  
**IFOPA, P.O. Box 196217, Winter Springs, FL 32719-6217**