

Pharmacia Retiree Matching Gifts: a program of the Pfizer Foundation

	DONOR FILLS IN THIS SECTION		
<p>PLEASE TYPE OR PRINT IN BLUE INK</p> <p>1. Fill in this section.</p> <p>2. Assure form is completed and signed.</p> <p>3. Send form with your gift to the organization.</p> <p>The donor's signature authorizes the recipient organization to report this gift to The Pfizer Foundation to apply for a Matching Gift.</p> <p>The countersignature by the authorized officer of the organization confirms receipt of the described gift.</p>	Name of Donor _____ ID Number _____ / /		<p>OUR ADDRESS</p> <p>Pharmacia Retiree Matching Gifts P.O. Box 8687 Princeton, N. J. 08543-8687</p> <p>Telephone: (888) 260-4587 Fax: (609) 799-8019</p>
	Home Address <input type="checkbox"/> Check if new address _____ Date of Retirement _____		
	City/State _____ ZIP Code _____ Daytime Telephone Number _____		
	e-mail Address (optional) _____		
	Name of Organization Receiving Gift _____ Date of Gift _____		
Program designation (if any) _____		\$ _____ , _____ .00 Amount of Gift (minimum \$25)	
<input type="checkbox"/> Cash/Check <input type="checkbox"/> Real Estate <input type="checkbox"/> Credit Card <input type="checkbox"/> Securities _____ Shares of _____		<p>CHECKLIST</p> <ul style="list-style-type: none"> ✓ Form is signed? ✓ Gift is \$25 or more? ✓ Gift Date entered? ✓ Org. Name entered? ✓ Clearly printed? ✓ Have guidelines listed on back been reviewed? 	
City/State _____ Name of Securities _____			

I hereby certify that the above donation is entirely my personal contribution, and that it is not in whole or in part the gift of another individual, the sum of the gifts of other individuals, or the gift of any group or organization. I also certify that this gift is solely for the use of the organization named and that neither I, nor any member of my family, nor any related third party, will receive any direct or tangible benefit from this gift. I also certify that I've read and complied with the program guidelines.

X _____
 Signature _____ Date _____

	RECIPIENT ORGANIZATION FILLS IN THIS SECTION			
<p>1. Verify Donor Section.</p> <p>2. Complete this section.</p> <p>3. Return form to address shown at top right.</p> <p>4. Applications must be received no later than March 1 for contributions made during the prior year.</p> <p>5. If first request see box at right.</p>	Print Name of Officer Authorized to Sign _____		<p>FIRST REQUEST</p> <p>If an organization has not previously participated in the Pharmacia Retiree Matching Gifts program, please include the following:</p> <ul style="list-style-type: none"> ◆ Copy of your 501(c)(3) Federal Tax Exempt letter from the IRS ◆ Mission statement 	
	Title _____			\$ _____ , _____ .00 Amount of Donor's Gift
	Organization Address _____			\$ _____ , _____ .00 Tax Deductible Portion of Gift
	City/State _____ Zip Code _____			Organization Telephone Number _____
	Website Address: _____			Employer Identification Number _____
	_____			_____

I confirm the above gift was received and this organization is tax exempt under section 501(c)(3) of the U.S. Internal Revenue Code. I further confirm that no direct, tangible benefit will accrue to the donor, to any member of their family, nor to any related third party as a result of this gift and it will be used to support the charitable objectives of the organization.

X _____
 Signature of Authorized Officer _____ Date _____
 (stamp signature is not accepted)