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| <input type="checkbox"/> \$50 | <input type="checkbox"/> \$500 |
| <input type="checkbox"/> \$100 | <input type="checkbox"/> \$750 |
| <input type="checkbox"/> \$200 | <input type="checkbox"/> Other |

Amount of donation \$ _____.

Donate type:

- One-Time
- Monthly

Select Program:

- Where It Is Most Needed
- W.R. Dancy, M.D. Student Loan Fund
- Georgia Physicians Leadership Academy
- Distressed Physicians Fund
- Physician in Training
- Yes, my company will match my donation

Name of company: _____.

My check is enclosed. *Please make check payable to the Medical Association of Georgia Foundation.*

Please charge my credit card.

Credit Card type: _____ Credit Card Number: _____

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**Please complete and return to:
MAG Foundation
1849 The Exchange, Suite 200
Atlanta, GA 30339**

**or text DONATE to 678-932-0991
(Choose MAG Foundation Donation)**