

Office of Development- Box # 450 Clarkson Ave. Brooklyn, NY 11203

FUNDRAISING: OPT OUT FORM

We have sent you materials to raise funds for SUNY Downstate Medical Center. If you do not wish to receive fundraising communications in the future, please complete this form and return it to the address documented above. We will make every effort to ensure that you do not receive any such future communications.

Patient Name	e:			
	Last Name	First Name	MI	
Address:			Telephone:	
				(daytime)
				(evening)
1. Do you wa	nt to stop receiving AL	L fundraising materials?		
Yes				
	ase describe what type	of materials you do not	want to receive:	
2. What is the	e title of the fundraising	material we sent you? (Optional)	
3 Is there :	a reason that you do	not want to receive for	uture fundraising co	mmunications?
(Optional)	a reason that you do	That want to receive it	atare randraising col	illialioations.
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Description o	f Personal Representa	tive's Authority Da	ate	