President’s Council Direct Debit Membership Form
Recurring Gift Membership Agreement

MEMBER INFORMATION
Name(s)__________________________________________________________
Street Address __________________________________________________________________
City ______________________ State _______ Zip ______________________
Cell __________________ Business _______________ Home ____________
Preferred Email Address________________________________________________________________________

PRESIDENT’S COUNCIL GIFT DESIGNATION (check one box)
☐ Unrestricted ☐ Dentistry ☐ Graduate ☐ Medical
☐ Nursing ☐ Health Professions ☐ Laredo ☐ South Texas

MEMBERSHIP LEVEL: ANNUALLY or MONTHLY
(check one box only)
☐ $1,000 ☐ $1,000
☐ $2,500 ☐ $84
☐ $5,000 ☐ $209
☐ $10,000 ☐ $417
☐ $10,000 ☐ $834

(Please choose either the monthly or the annual recurring payment option.)

BANK DRAFT OPTION (please attach a voided check)
I hereby authorize The UT Health Science Center at San Antonio to initiate debit entries to my (our) bank account indicated below and the financial institution below, to debit the same to such account.

Financial Institution ________________________________ Branch ______________________
City ___________________________ State _______ Zip ______________________
Routing No. _______________________________________________________________________
Account No. _______________________________________________________________________

CREDIT CARD OPTION
I hereby authorize The UT Health Science Center at San Antonio to initiate monthly charges to my credit card.

Type of card: ☐ AMEX ☐ MasterCard ☐ Visa
Name on Card: ________________________________ Card Number: ________________________________
Expiration Date ____________________________ Security #: ____________________________

This authority is to remain in full force and effect until The UT Health Science Center at San Antonio has received written notification from me of its termination in such time and manner as to afford The UT Health Science Center San Antonio a reasonable opportunity to act upon my request. This authority will remain in effect until I give a reasonable notification to terminate this authorization.

Signature ____________________________ Date ___________________

Please mail your form to Gift Processing at the address listed below or email it to: GiftProcessing@uthscsa.edu

Thank you for making lives better!

Office of Institutional Advancement, MC-7835 • 7703 Floyd Curl Drive • San Antonio, TX 78229-3900 • 210-567-5001