



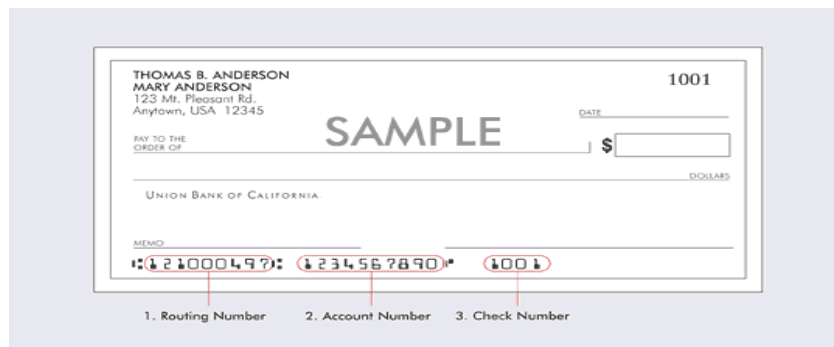
**Milka Clarke Stroke Brain Trauma Foundation Authorization
Agreement for Direct Deposits (EFT Debits)
For ONE TIME Or Monthly Ongoing Giving**

I (we) hereby authorize Milka Clarke Stroke Brain Trauma Foundation to initiate Debit entries to my (our) () Checking () Savings account (Select one) indicated below at the depository financial institution named below, hereinafter called DEPOSITORY, and to Debit the same to such account. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law.

DEPOSITORY NAME _____ BRANCH _____

DISTRICT: _____ PARISH: _____

ROUTING NUMBER _____ ACCOUNT # _____



This authorization is to remain in full force and effect until Milka Clarke Stroke Brain Trauma Foundation has received written notification from me (or either of us) of its termination in such time and in such manner as to afford Milka Clarke Stroke Brain Trauma Foundation and DEPOSITORY a reasonable opportunity to act on it.

NAME(S) _____ (Please print.)

DATE _____ SIGNED _____

DATE _____ SIGNED _____

Please also note that you may stop or change this auto-debit from your account at any time.

I prefer to have my account debited in the amount of _____ beginning
on the 15th of the month of _____, 20_____. Or For a **ONE TIME** Donation.

We would like to email our "Milka Clarke Stroke Brain Trauma Foundation Newsletter" to you. It is filled with stroke awareness information, upcoming events, prayer, and praises.

Email address: _____

Thank you for your partnership with the Milka Clarke Stroke Brain Trauma Foundation!