



Workplace Partnership

Enrollment Form

COUNT US IN!

We would like to join the **Donate Life Workplace Partnership**. We pledge to provide information about donation to our employees.

Name of Company _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

Please contact _____ to coordinate our Donate Life Workplace Partnership efforts. *(Name of your employee who will coordinate efforts.)*

LAORA plans to recognize businesses that join the Donate Life Workplace Partnership campaign on our Website, www.laora.med.miami.edu. If you would like your business to be included, please check the box below.

I give LAORA Permission to list our company name as shown above on the LAORA Website as a participating business in the Donate Life Workplace Partnership campaign.

Your Name _____

Title _____

Signature _____

Thank you for joining the Donate Life Workplace Partnership. You will soon receive the materials you requested to help you with your efforts to save and improve lives. Meanwhile, please visit our Website at www.laora.med.miami.edu for more information about LAORA and donation.

Please submit this enrollment form using one of the methods listed below:

MAIL

Life Alliance Organ Recovery Agency
Highland Professional Building
Attn: Donate Life Workplace Partnership
1801 NW 9th Avenue, Suite 150-A
Miami, Florida 33136

FAX

305.243.7628

EMAIL

ktrachy@med.miami.edu