A GIFT OF ISRAEL PAYMENT REQUEST FORM

Please fill in Section 1, sign and return to Lisa Goodman at the JEC by fax: (216) 371-2523 mail: 2030 S. Taylor Rd., Cleveland Hts., 44118 or scan and email to agiftofisrael@jecc.org at least 2 months before the funds are due to the program.

1. Participant Information	Da	te	
Student's Name			
Address:			
City,Zip:	Phone:		
Jewish Day School or Synagogue Schoo	bl:	Grade:	
Should the student withdraw from the applicable) must be returned to the Je payment, it cannot come from these f	ewish Education Center of unds.	Cleveland. If the program	
Parent's Signature(Funds will not be prod	cessed without this signature)	Parent Email address	_
Funds will be sent to the Israel Progra	am unless otherwise discu	ssed with Lisa Goodman.	
Israel Program Name:	Acce	ptance Date:	
Make check payable to:			
Address:	Depa	arture Date:	
City, State, Zip:	Attention:		
JEC USE ONLY-VERIFICATION OF AC 2. Savings Information a. Student Account Number: Custodial Savings Total: Date Withdrawal Authorized: b. School Account Number: Number of Years: x \$ Date Withdrawal Received: 2nd School Account Number: Number of Years: x \$ Date Withdrawal Received: c. Jewish Federation of Cleveland Manumber of Years: x \$ 80 Number of Years: x \$ 10 Bar/Bat Mitzvah/Rite of Age Gift Date Received:	+ Int. =	\$ \$ \$ \$ \$	
d. Total Sent to Program Processed by:		\$	

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