

CONTRIBUTION FORM

Yes, I want to help Family Medicine speak with a stronger voice in Washington, D.C.!

FAMMEDPAC

Family Medicine's Champion in Washington, D.C.



(Please print)

Name*: _____

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City, State, Zip*: _____

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**Federal election law requires FamMedPAC to report the name, address, occupation, and name of employer for anyone who contributes \$200.00 or more in a calendar year.*

Contribution: \$5,000 \$2,500 \$1,000
 \$500 **\$365 (Club George — Just \$1 a day!)** Other _____

Payment Options:

Personal check payable to FamMedPAC
 Cash (may not exceed \$100)
 Personal credit card: AmEx MasterCard Visa Discover
 In one payment
 In monthly installments — Credit card contributors only. Payments will be automatically deducted in monthly installments upon receipt of your pledge. Amount of Monthly Payment: _____
Until the following date: _____(month/yr)

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Signature _____

I am aware of the political purposes of FamMedPAC, understand that contributions to FamMedPAC are purely voluntary and that these suggested contribution amounts are only guidelines. I further understand that I will not be favored or disadvantaged by reason of the amount of my contribution or a decision not to contribute.

CONTRIBUTIONS TO FamMedPAC ARE NOT TAX DEDUCTIBLE FOR FEDERAL INCOME TAX PURPOSES.



Please return this form, along with your contribution to:

FamMedPAC, 2023 Massachusetts Ave., NW
Washington, D.C. 20036 or fax to 202-232-4090

For more information, please contact the
Director of FamMedPAC, Mark Cribben at 1-888-271-5853