

CONTRIBUTION FORM

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FAMMEDPAC

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



(Please print)

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Employer*: _____

**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:

- Check payable to FamMedPAC — *Is this a* *corporate check or a* *personal check?*
- Cash (may not exceed \$100)
- Personal credit card only: AmEx MasterCard Visa Discover (minimum contribution of \$25)
- 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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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, 2021 Massachusetts Ave., NW
Washington, D.C. 20036 or fax to 202-232-9044

If you have any questions or comments, please call the FamMedPAC hotline at 1-800-494-3240.