FamDocPAC

Contribution Form

Yes, I want to help Family Medicine speak with a stronger voice in Mississippi!

Name (please print)*:	
Address*:	
City/State/ZIP*:	
Occupation*:	
Employer*:	
Today's Date:	
Phone:	E-mail:

Federal election law requires FamDocPAC 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 ☐ $1,000 ☐ $365
☐ $2,500 ☐ $500 ☐ $100 ☐ Other ____________

Payment Options:
☐ Personal check payable to **FamDocPAC**
☐ Cash (If cash, may not exceed $100)
☐ Personal Credit Card: ☐ American Express ☐ Master Card ☐ Visa ☐ Discover
☐ In one payment
☐ Monthly Installments (credit cards only). *Payments automatically deducted in monthly installments upon receipt of your pledge. Amount of Monthly Payment: __________*

First Date to Charge My Card (month/day/year): __________ Last Date to Charge My Card: _______________

Card Number: ____________________________ Expiration Date: _______3 digit code (4 for AMEX)__________

Name on Card (print): ____

Cardholder's Billing Address:____

Signature: ____

I am aware of the political purposes of FamDocPAC; understand that contributions to FamDocPAC 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 FamDocPAC ARE NOT TAX DEDUCTIBLE FOR FEDERAL INCOME TAX PURPOSES.

Please return this form along with your contribution to:
FamDocPAC, 755 Avignon Drive, Ridgeland, MS 39157 or FAX (601) 853-3002.

Contact the MAFP Executive Director Beth Embry at (601) 853-3302 or beth@msafp.org with any questions.