

# Response to Support DOCPAC and Effective Medical Liability Reform

Please complete, detach, and mail or fax this form  
with your financial support to:

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FAX (707) 226-0153

[www.thedoctors.com](http://www.thedoctors.com)

**YES, I wish to contribute \$ \_\_\_\_\_ to DOCPAC.**

*Federal law requires the following information. PLEASE PRINT CLEARLY.*

1  **I have enclosed a PERSONAL CHECK payable to DOCPAC.**

Name \_\_\_\_\_ TDC Policy Number \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Daytime Telephone \_\_\_\_\_ My E-mail Address \_\_\_\_\_

Name of Employer \_\_\_\_\_ Occupation \_\_\_\_\_

*Please make checks payable to DOCPAC. DOCPAC is a voluntary political organization. According to federal income tax law, DOCPAC contributions are not deductible as charitable contributions. Contributions are requested for DOCPACs active in California, Colorado, Florida, Montana, Nevada, and Washington to engage in medical liability reform political action. Contributions received from subscribers in states with an active DOCPAC will be directed to those state DOCPACs.*

2  **I authorize the use of my \_\_\_\_\_ Visa®, \_\_\_\_\_ MasterCard®, or \_\_\_\_\_ American Express®**

Name \_\_\_\_\_ TDC Policy Number \_\_\_\_\_

Daytime Telephone \_\_\_\_\_ Fax \_\_\_\_\_

My E-mail Address \_\_\_\_\_ Billing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

If not self-employed, name of employer \_\_\_\_\_ Occupation \_\_\_\_\_

Credit Card Number \_\_\_\_\_ Expiration Date \_\_\_\_\_

Cardholder or billing name as it appears exactly on the card \_\_\_\_\_

Authorized cardholder's signature \_\_\_\_\_ Date \_\_\_\_\_

Yes, I am interested in attending DOCPAC-sponsored political events in my state legislative district.

Yes, I am interested in communicating with my state representative or state senator regarding medical liability reform issues via: