RESPONSE TO SUPPORT FEDERAL DOCPAC AND MEDICAL LIABILITY REFORM

❑ **YES, I wish to contribute $ _____ to DOCPAC.**

Federal law requires the following information. PLEASE PRINT CLEARLY.

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

Name _____ 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. ***Federal campaign law requires that checks be drawn on personal rather than corporate accounts.*** *DOCPAC welcomes contributions of up to $5,000 per person per calendar year. Federal law prohibits contributions from corporations, labor unions, and foreign nationals.*

2 ❑ **I authorize the use of my** ☐ **Visa** ☐ **MasterCard** ☐ **American Express**

Name _____ 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 congressional district.

❑ Yes, I am interested in communicating with my congressional representative or U.S. Senator regarding medical liability reform issues via: ☐ Meeting ☐ Telephone ☐ Letters ☐ E-mail

Please complete and mail or e-mail this form with your financial support to:

Government Relations • The Doctors Company
185 Greenwood Road • Napa, CA 94558
governmentrelations@thedoctors.com

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