

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 PERSONAL 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 Fax E-mail

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

*Government Relations • The Doctors Company
185 Greenwood Road • Napa, CA 94558
Fax (707) 226-0153*

 **THE DOCTORS COMPANY**
www.thedoctors.com/docpac