



Yes, I want to support the NPA!

Name: _____ Date: _____

I would like to make a **monthly** contribution of \$ _____ Preferred start date: _____

I prefer to make a **one-time** contribution of \$ _____

_____ \$1000 _____ \$500 _____ \$250 _____ \$100 _____ \$50 _____ \$25 _____ Other

I have enclosed a check payable to the "National Physicians Alliance"

Please charge my credit card: Master Card Visa American Express Discover

Credit Card Number: _____

3- or 4-digit CVV code: _____ Expiration date: _____

Cardholder Name: _____

Signature of Cardholder: _____

Address: _____
(must match the credit card billing address)

City, State, Zip: _____

Phone: _____ Cell: _____

Graduate Degree(s): _____ If Physician Med School Graduation Year: _____

Medical Specialty: _____

E-mail (please print clearly): _____

My employer will match my gift

My gift is in memory/honor (please specify) of:

Name Listing

I wish to remain anonymous

Please list my name in recognition materials as:

Please return this form to the:
National Physicians Alliance
888 16th St., NW, Suite 800, PMB #835, Washington DC, 20006

OR make your donation on-line at:
www.npalliance.org

