OPTOMETRY's PAC

Supporting those who support Optometry

PAYMENT FORM

Name: _____

Address: _____

City/State/Zip: _____

Phone: _____ **Email:** _____

Total Amount of Payment $_____

____ **Credit Card** (VISA/MasterCard/AmEx) ____ **Check enclosed** *(Payable to: "Optometry's PAC")*

Payment Method: _____Monthly ____Quarterly ____Semi-Annually ____One-time gift

Credit Card Information

Card Type (Visa, MC, AmEx)	**Account/Card Number**	**Expires** (Month/Year)

Name on Card (Print)	**Amount**
	$

I hereby authorize the above amount to be charged to my credit card.

Signature: _____ **Date:** _____

Thank you for supporting Optometry's PAC !!

Is there an Indiana Representative or Senator that you know on a personal basis? If so, please list their name(s) below:

_____

_____

Send payment to: Optometry's PAC
PO Box 3363
Carmel, IN 46082
Fax: (317) 237-3564

Contributions to Optometry's PAC are not tax deductible.