Yes! I would like to support and join the Foundation Sustainer's Circle.

Please use the enclosed envelope and send the form below. Thank you!

____

Name as it appears on card

____

Credit Card Number

Expiration Date ______________________________

Please indicate below the level of your monthly contribution:

❑ $10 ❑ $25 ❑ $50 ❑ $100

$__________ Other Amount

Name ____________________________________

Address ___________________________________

City _____________________________________

State ______________________ Zip ____________

Email ____________________________________

Phone ____________________________________

I hereby authorize The Foundation of the Pennsylvania Medical Society (the Foundation) to initiate debit entries to my Credit Card. Each such debit shall be made on the________ (day of the month, i.e., 1st or 15th) of each month in the amount of $________per month. Each such debit shall continue on a monthly basis indefinitely or until the following stop date:________________________________