



SCOPA PAC Pledge Form

Please fax or e-mail your completed SCOPA PAC pledge form to the SCOPA Office at 803-799-1064 or info@sceyedoctors.com If you have any questions, please contact Jackie Rivers or Anna Balderson at the SCOPA office by calling 803-799-6721 or toll free 877-799-6721.

Name: _____

Billing Address: _____

City: _____ State: _____ Zip Code: _____

Phone number: _____ E-mail address: _____

*** Please note, a receipt will be sent to the e-mail that is provided above!

We accept Visa, MasterCard, Discover and American Express

Please check the appropriate box and circle your preferred payment schedule if applicable:

- ☐ Visionary Level: \$2,000 \$500 per quarter \$167 per month
- ☐ Presidential Level \$1,000 \$250 per quarter \$84 per month
- ☐ Congressional Level \$500 \$125 per quarter \$42 per month
- ☐ Dollar A Day: \$365 \$91.25 per quarter
- ☐ Capitol Club: \$200 \$50 per quarter
- ☐ SCOPA PAC: \$ _____
- ☐ SCOPA Student \$20

SCOPA suggested giving amounts based on years in practice:

First Year:	\$100	Fifth Year:	\$500
Second Year:	\$200	Tenth Year:	\$1,000
Third Year:	\$365	Twentieth Year:	\$2,000

BILLING INFORMATION: Please charge my Visa, Master Card or American Express (circle one) \$ _____ / _____ (annually, quarterly, monthly). Please fill in your dollar amount and desired billing schedule.

Credit Card Statement: By signing this agreement, I hereby authorize the SCOPA to deduct the amount outlined above from my credit card. Corporate contributions are illegal. Only personal credit cards are accepted.

Name as it appears on card: _____

Credit Card Number: _____

Expiration Date: _____ CVV: _____

Signature: _____ Date: _____

NOTE: This pledge will remain in effect each year until changed in writing by the person making the pledge.

Thank you for your support of your profession!