

WISMedPAC WISMedDIRECT

Member Application Form

Name: _____

Specialty: _____

Preferred Mailing Address: _____

Preferred Phone Number: _____

Fax Number: _____

Preferred E-Mail: _____

Credit Card Information

Visa MasterCard Discover

Name as it appears on card: _____

Card Number: _____ Expiration Date: _____

WISMedPAC Donor Levels

- Champion of Medicine \$1,000 and up (\$850 WISMedDIRECT, \$150 WISMedPAC *)
- Ambassador's Club \$500-\$999 (\$350 WISMedDIRECT, \$150 WISMedPAC *)
- Sustaining Member \$200-\$499 (\$100 WISMedDIRECT, \$100 WISMedPAC *)
- Sponsor Member \$150-\$199 (\$75 WISMedDIRECT, \$75 WISMedPAC *)
- Friend Other Amount \$ _____

Please indicate distribution (WISMedDIRECT \$ _____, WISMedPAC \$ _____)

**Contributions will be distributed in this manner unless contributor requests alternate distribution.*

Please mail or fax this form to Government Relations, Wisconsin Medical Society, PO Box 2295, Madison, WI 53701, or 608.442.3802 (fax). Call toll-free 866.442.3800, ext. 3764 or e-mail govtrel@wismed.org for more details.

Personal checks should be made payable to WISMedPAC / WISMedDIRECT

WISMedPAC and WISMedDIRECT political contributions are voluntary and not tax deductible. **If your practice is incorporated, these dues should be written on a personal check.** Copies of the WISMedPAC and WISMedDIRECT reports are filed with the Wisconsin State Elections Board.