MassAFP MASSACHUSETTS ACADEMY of FAMILY PHYSICIANS

# MAFamMedPAC Contribution/Pledge Form

**Contributor Information**

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City, ST Zip _____

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Employer _____

**Pledge Information**

I (we) pledge a total of $_____ to be paid:

☐ Now, for a one-time donation ☐ Annually for the next _____ years

I (we) plan to make this contribution in the form of:

☐ check ☐ credit card

Credit card type / Exp. Date _____

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Signature(s) _____

Date _____

**Please make checks payable to:**
Massachusetts Academy of Family Physicians
860 Winter St.
Waltham, MA 02451