



WE INVITE YOU TO JOIN OUR MONTHLY GIVING SOCIETY *PA PARTNERS IN CARE*

Yes, I accept your invitation to join *PA Partners In Care*, the PA Foundation's monthly giving society.

Name: _____

Address: _____

City/State/Zip: _____

Telephone: _____ E-mail: _____

Amount: \$ _____ (Minimum of \$25 per transaction)

To be charged or debited: _____ Monthly _____ Quarterly _____ Annually

Visa MasterCard AMEX

Card Number _____ Expiration Date _____

Name as it appears on card _____

Direct Debit/Checking Account (PLEASE ATTACH A VOIDED CHECK)

Terms of Agreement: I authorize the Physician Assistant Foundation to charge my credit card or debit my bank account in the amount, and at the times, that I have designated above. This agreement remains in effect until I provide the Physician Assistant Foundation written notice of its termination or change in payment schedules. Each gift will appear on my credit card or bank statement, and this will serve as my receipt.

Cardholder's/Bank Account Owner's Signature _____ Date _____

