Pennsylvania Academy of Dermatology and Dermatologic Surgery

Public Health Education Fund - Individual Commitment Form

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

Check your desired level of participation:

☐ **Platinum Donor**	$10,000
☐ **Sun Education Society**	$5,000
☐ **Sun Protection Scholar**	$2,500
☐ **Sun Protection Contributor**	$1,000
☐ **Other**	$_____

You may donate over a 3-year period or all at once. I choose to donate $_____ per year for _____ years, which would bring my total gift to $_____.

All donors have the option to be listed as a contributor on our website

☐ Check here if you do not wish to be listed as a contributor on our website

Payment Information

☐ Check — Checks should be written to The Foundation of the Pennsylvania Medical Society and marked for the PAD's Public Health Education Fund

☐ Credit Card (see below) — Your gift will be charged to The Foundation of the Pennsylvania Medical Society, under the PAD's Public Health Education Fund

AMOUNT $_____USD

CREDIT CARD TYPE (circle one) ☐ Visa ☐ Master Card ☐ Discover

CREDIT CARD # _____

CARD CV2 # _____ EXPIRATION DATE _____

BILLING ADDRESS _____

_____

NAME ON CARD _____
(As it appears on card)

_____ _____
SIGNATURE DATE

777 E. Park Drive, PO Box 8820, Harrisburg, PA 17105-8820; phone: (866) 650-3376; paderm@pamedsoc.org