Please fill out this form and return to RxPAC, c/o PSSNY,
210 Washington Ave. Ext., Albany, NY 12203, Fax 518.464.0618
All fields are required. Questions? Call 800.632.8822

# NYS RxPAC Membership Contribution Form

**Billing Information - information must match the information on your credit card**

Name: ______________________ Company: ______________________
*If applicable*

Address: ______________________

City: ______________________ State: ________ Zip Code: ____________

Phone Number: ______________________ Fax Number: ______________________

Email Address: ______________________

RxPAC Membership Levels:

- O Diamond - $400.00 per month
- O Titanium - $200.00 per month
- O Platinum - $100.00 per month*
- O Gold - $50.00 per month
- O Silver - $25.00 per month

* Platinum is the suggested minimum contribution level for pharmacy owners.

This is a(n): O Individual Contribution O Company/Corporate Contribution

Corporate Name/LLC: ______________________

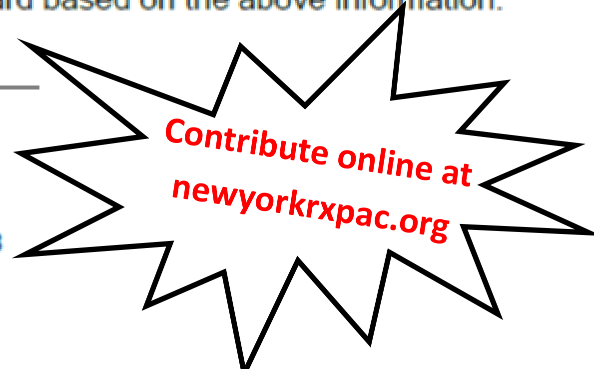
**Please charge my:** O Visa O MasterCard O Discover O American Express

CC Number: ______________________ Exp. Date: ____________

On what day: ______________________ Code on Back of Card: ________
Example: the 15th of every month

By signing this form I authorize PSSNY to charge to my credit card based on the above information.

Signature: ______________________





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210 Washington Ave. Ext.
Albany, NY 12203
Ph: 800.632.8822 or Fax: 518.464.0618
Email: staff@pssny.org


RxPAC contributions are not tax deductible.