



SAMPAC Membership Application

Contribution Level:

- Physician Membership ___\$100
- Spouse/Alliance Membership ___\$100
- Business Contribution ___\$500

Full Name/Business Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Business Phone: _____ Home Phone: _____

E-Mail Address: _____

Occupation: _____ Employer: _____

CREDIT CARD PAYMENT

Credit Card: ___ Discover ___ Mastercard ___ Visa (3 digit code on back of card): _____

Card Number: _____ Exp. Date: _____

Complete billing address on statement: _____

Authorized Signature: _____

CHECKS MADE PAYABLE TO: SAMPAC

Please return application to: **SAMPAC**
4153 Clark Road
Sarasota, FL 34233