

OREGON PHARMACISTS FUND

CONTRIBUTOR INFORMATION

First Name Last Name Date

Employer and Street Address

City State ZIP

Street Address (Home)

City State ZIP

Home Phone Work Phone

Email Address

I am eager to support the future of pharmacy in Oregon at this strategic time with my monthly donation to the Oregon Pharmacists Fund of:

\$100 \$75 \$50 \$25 \$10

OR

Please accept my one-time donation of:

\$1000 \$500 \$250 \$100 \$50 Other _____

Charge my account in the amount of \$_____ to my:

- VISA (billing ZIP code)_____
- MasterCard
- American Express
- Discover

Account # _____ Expire (MM/YY) _____

Signature: _____