Contribution Form

To Contribute:

Email: emactionfund@acep.org
FAX: 972-580-2816
Phone: 800-798-1822, ext. 3170

Mail: Emergency Medicine Action Fund
P.O. Box 61991
Dallas, TX 75261-9911

Step 1. CONTRIBUTOR INFORMATION

Select the contribution type.

- ☐ Individual
- ☐ Group
- ☐ Coalition

Encourage your hospitals, chapters and sections to combine resources and increase the level of commitment to the Emergency Medicine Action Fund during the 2018 campaign. By forming a coalition, you and your colleagues could be eligible to have representation on the EMAF Board of Governors.

Contributor (Group Name or Individual Donor Name as it is to appear in print)

Coalition Name (if applicable):

Contact Name

Street 1

Street 2

City | State | Zip/Postal Code

Phone Number | E-Mail Address

Step 2. CONTRIBUTION INFORMATION

2018 Contribution Amount: _____

While tax deductibility can only be determined by contributor's tax advisors, the intent of the Emergency Medicine Action Fund is to use contributor funds for items typically deductible as business expenses.

Signature | Date

Printed Name

Step 3. PAYMENT INFORMATION

Select your payment method.

☐ Enclosed is my check made payable to ACEP (US Dollars Only)

Charge my:

- ☐ VISA
- ☐ Amer Express
- ☐ MasterCard
- ☐ Discover

Name (as it appears on the card)

Credit Card Number

*Card ID Number | Expiration Date

Billing Zip Code

Authorization Signature

*The Card ID Number is a 4-digit code on American Express (located on the front), or a 3-digit code on VISA, MasterCard or Discover branded credit or debit cards (located on the back).