



CONTRIBUTE ONLINE TODAY AT WWW.CALHOSPITAL.ORG/CONTRIBUTE State Contribution Form

Yes, I wish to support the California Hospital Association Political Action Committee (CHPAC) by making a contribution of:

Total Amount

- \$5,000
- \$3,000
- \$2,000
- \$1,000
- Other (\$ _____)

Pledges must be paid in full by December 31. Donation amounts will be prorated based on achieving desired PAC level by December 31 of that calendar year based on month of contribution. If you select automatic renewal, your payment plan will be recalculated for each subsequent year.

- This is a personal donation for which I will not be reimbursed by my employer or any other entity.
- Automatic yearly renewal. Payments will automatically **renew on a yearly** basis. To cancel, call (916) 552-7561.

Payment Information

- Check enclosed. Make payable to CHPAC (#790733).

I would like to pay my total contribution amount in credit card payments:

- One-time
- Monthly
- Quarterly

Card Number: _____ Expiration Date: _____ CW Number: _____

Name on Card: _____

Billing Address: _____ City: _____ State: _____ Zip: _____

Personal Information

CHPAC is required to collect the following information:

Name: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____

Email: _____

Occupation/Title: _____

Full Name of Employer: _____

Signature

Date

CHPAC Goal Credit

- Hospital CEO to receive credit:

Note:

Contributions or gifts to CHPAC are not deductible as charitable contributions for federal or state income tax purposes.

Contribution levels are suggestions — you may contribute more or less. You have the right to refuse to contribute to CHPAC without reprisal. The decision to participate will in no way affect your employment or job status.