MPHP Contribution Payment Form

To make a contribution to the Medical Professionals Health Program, please complete this payment form with your credit card information or otherwise indicate how you would like to send payment. Please send completed form via email to hlamonica@mma-mphp.org, or to the fax number or mailing address provided below.

Organization:_____ Date:_____

Name of individual making payment:_____

Email:_____

Phone number:_____

Contribution amount: _____

Please select a payment option:

☐ **Payment by Check**
Please mail check to: P.O. Box 69, Manchester, Maine 04351.

☐ **Payment by Credit Card**
Your credit card will be charged the contribution amount indicated above.

Name on Credit Card: _____

Address on Credit Card: _____

Card Type: ☐ Visa ☐ MasterCard

Credit Card number: _____ expiration date:_____

3 digit CVV_____

Authorizing Signature:_____