



NMA DIABETES EDUCATION PROGRAM CONTRIBUTION FORM

REQUESTED AMOUNT: \$100.00 (minimum)

Please Print:

Name: _____

Address: _____

City/State: _____

E-Mail: _____

Phone: _____ Fax: _____

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My voluntary contribution is attached in the following form (Select One):

- Check (Indicate Check Number and Amount): \_\_\_\_\_
- Cash (Indicate the Amount): \_\_\_\_\_
- Credit Card: Please complete information below.

**Please check one:**

\_\_\_ AMEX    \_\_\_ VISA    \_\_\_ MC    \_\_\_ DISCOVER

Credit Card No: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ VCODE \_\_\_\_\_

Amount: \_\_\_\_\_ Signature: \_\_\_\_\_

\*For email purposes, typed in name is equivalent to signature

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To Mail Form:
NMA Vision Focus Initiative
National Medical Association
8403 Colesville Road, Suite 920
Silver Spring, MD 20910

Or Fax Form to: 301-495-0359
Or Submit Form via Email: