

**Contribution Credit Card Payment Form**

*(Contributions to RIMPAC must be made via a personal credit card or check.)*

Contributor's Name: \_\_\_\_\_

Credit Card Payment:           VISA \_\_\_                   MC \_\_\_                   AMEX \_\_\_

Card Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Name on Card: \_\_\_\_\_

Billing Address: \_\_\_\_\_

(street)

(city)

(state zip code)

Please mail to:  
RI Medical Society  
405 Promenade Street, Suite A  
Providence, RI 02908