



Connecticut Society of Eye Physicians

2021 COMECC Contribution Form

P.O. Box 854, Litchfield, CT 06759

Fax to 860-567-3591 or Email debbieosborn36@yahoo.com

This portion can be faxed back to 860-567-3591 for your 2021 COMECC voluntary contribution using a credit card

_____ Visa _____ Mastercard _____ American Express

____/____/____/____/____/____/____/____/____/____/____/____/____/____/____/____/

(16 digit card number)

____/____/____

(Expiration date)

____/____/____

*3 digit # that appears on the back of the Visa/Mastercard

____/____/____/____

*4 digit # that appears on the front of the American Express

\$ _____ Total amount charged **RECOMMENDED AMOUNT \$275.00**

_____ **\$300** _____ **\$500** _____ **\$750** _____ **\$1,000** _____ **other**

(Card holder's name)

(Card holder's signature)

(Card holder's address where statement is mailed)

(Practice name)

(City - State)

5 digit Zipcode (required) _____

_____ Email address

Please print the name on the credit card and who COMECC is being paid for:

Personal checks can be mailed to:

COMECC, 26 Sally Burr Road • P.O. Box 854 • Litchfield, CT 06759

email form to eyemaster2020@yahoo.com or fax to 860-567-3591