Connecticut Society of Eye Physicians

2014 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
2014 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 $250.00**

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

_____ _____

(Card holder's name) (Card holder's signature)

_____ _____

(Card holder's address where statement is mailed) (Practice name)

_____ 5 digit Zipcode (required) _____

(City - State)

_____ 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