



FixRx Contribution Form

Billing Information - information must match the information on your credit card

Name: _____ Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Contribution Amount: \$ _____

One-time or Recurring contribution? (Circle)

This contribution is paid by a: Personal credit card Company/Corporate credit card

Legal Name of Contributor: _____

Please charge my: Visa MasterCard Discover American Express

CC Number: _____ Exp: _____ CVV: _____

By signing this form I authorize PSSNY to charge my credit card based on the above.

Signature: _____ Date: _____

FixRx, c/o PSSNY
210 Washington Ave. Ext. Albany, NY 12203
Ph: 800.632.8822 or Fax 518.464.0618
Email: FixRx@pssny.org

