



**Ohio
Psychiatric
Physicians
Foundation**

Advancing the Understanding of Mental Illness

OPPF CONTRIBUTION FORM

**I would like to support the newly-revitalized Foundation in achieving its purpose
with a tax-deductible contribution!**

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

E-mail _____

___ I would like to serve on the Foundation Board or on a committee.

I wish to make a flat contribution in the amount of:

___ \$50 ___ \$150 ___ \$200 ___ \$ 250 ___ \$500 ___ (other) \$_____

___ I wish to make a monthly contribution of \$ _____ (amount) for the next twelve months to be charged to my credit card below automatically by the OP PF

Method of Payment:

___ Check enclosed made payable to: OP PF

___ Credit Card: ___ Visa ___ MasterCard ___ Discover ___ American Express

Account # _____ Exp. Date _____

Street Address and Zip code for credit card billing (if different from above)

Signature _____