

**Year 2019 BeMedWise Council - Supporter Invoice**

Membership Year: January 1 - December 31, 2019

Send your payment to:  
BeMedWise  
50 Whittemore Street, PO Box 219  
Gloucester, MA 01931

**Invoice Date:**  
**Payment Due:**  
**Dues Amount: \$**

\*Please make any corrections below\*

**Name:**  
Title:  
Organization:  
Address:  
  
Telephone:  
Fax:  
E-mail:  
Web:

**Payment Method**

NeedyMeds Federal Tax ID: 46-3091990

\_\_\_\_\_ **Check payable to BeMedWise (U.S. Dollars)**  
 \_\_\_\_\_ **Electronic Direct Deposit** Contact Deborah.Davidson@needymeds.org to obtain bank routing information.  
 \_\_\_\_\_ **Credit Card**  
       \_\_\_\_\_ **Visa**                    \_\_\_\_\_ **Mastercard**                    \_\_\_\_\_ **American Express**  
       \_\_\_\_\_ **Discover**            \_\_\_\_\_ **Diner's Club**                    \_\_\_\_\_ **JCB**

Card # : \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Expiration Date: \_\_\_\_\_ / \_\_\_\_\_                    Security Code: \_\_\_\_\_

Authorized Signature :

**Please Check Supporter Category and Corresponding Amount:**

\_\_\_\_\_ **\$15,000      Champion**  
 \_\_\_\_\_ **\$10,000      Ally**  
 \_\_\_\_\_ **\$ 2,500      Friend**  
 \_\_\_\_\_ **\$ 1,000      Non Profit**  
 \_\_\_\_\_ **\$ 200      Public Sector**  
 \_\_\_\_\_ **Tax-deductible contribution (Optional – indicate amount)**  
 \_\_\_\_\_ **TOTAL AMOUNT**

**Remit payment to BeMedWise at the above address.**  
*Please return one copy of this invoice with your remittance.*

**Questions contact:** Deborah Davidson at [deborah.davidson@needymeds.org](mailto:deborah.davidson@needymeds.org)  
**TEL:** (978) 281-6666 **FAX:** (206) 260-8850  
**Website:** [www.BeMedWise.org](http://www.BeMedWise.org)