

**SCHEDULE A (FEC Form 3X)**  
**ITEMIZED RECEIPTS**

 Use separate schedule(s)  
 for each category of the  
 Detailed Summary Page

FOR LINE NUMBER: PAGE 59 OF 105

(check only one)

<input checked="" type="checkbox"/> 11a	<input type="checkbox"/> 11b	<input type="checkbox"/> 11c	<input type="checkbox"/> 12
<input type="checkbox"/> 13	<input type="checkbox"/> 14	<input type="checkbox"/> 15	<input type="checkbox"/> 16
<input type="checkbox"/> 17			

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NAME OF COMMITTEE (In Full)

**AMERICAN MEDICAL ASSOCIATION POLITICAL ACTION COMMITTEE**

Full Name of Individual (Last, First, Middle Initial) or Full Organization Name

**A. MEDLOCK, MICHAEL, DEAN, , MD**

Mailing Address 43 TURNING MILL RD

 City  
 LEXINGTON

 State  
 MA

 Zip Code  
 02420-1319

 FEC ID number of contributing  
 federal political committee.

 Name of Employer (for Individual)  
 NORTH SHORE MEDICAL CENTER

 Occupation (for Individual)  
 PHYSICIAN

Receipt For:

☐ Primary ☐ General  
☐ Other (specify) ▼

Aggregate Year-to-Date ▼

Date of Receipt

M M M	/	D D D	/	Y Y Y Y Y Y
10		06		2019

Transaction ID : A176D6EE6A4674980995

Amount of Each Receipt this Period

☐ Memo Item

Full Name of Individual (Last, First, Middle Initial) or Full Organization Name

**B. MIGLIORI, MICHAEL, E, , MD**

Mailing Address 1 HOPPIN ST

 City  
 PROVIDENCE

 State  
 RI

 Zip Code  
 02903-4141

 FEC ID number of contributing  
 federal political committee.

 Name of Employer (for Individual)  
 OPHTHALMIC PLASTIC SURGERY

 Occupation (for Individual)  
 PHYSICIAN

Receipt For:

☐ Primary ☐ General  
☐ Other (specify) ▼

Aggregate Year-to-Date ▼

Date of Receipt

M M M	/	D D D	/	Y Y Y Y Y Y
10		06		2019

Transaction ID : A52FD911109A04572842

Amount of Each Receipt this Period

☐ Memo Item

Full Name of Individual (Last, First, Middle Initial) or Full Organization Name

**C. MILSTEIN, MARK, JOSEPH, , MD**

 Mailing Address 111 E 88TH ST  
 APT 4F

 City  
 NEW YORK

 State  
 NY

 Zip Code  
 10128-1158

 FEC ID number of contributing  
 federal political committee.

 Name of Employer (for Individual)  
 MONTEFIORE MEDICAL CENTER

 Occupation (for Individual)  
 PHYSICIAN

Receipt For:

☐ Primary ☐ General  
☐ Other (specify)

Aggregate Year-to-Date ▼

Date of Receipt

M M M	/	D D D	/	Y Y Y Y Y Y
10		06		2019

Transaction ID : A92DF664903D443F78DB

Amount of Each Receipt this Period

☐ Memo Item

**SUBTOTAL** of Receipts This Page (optional)..... ►

**TOTAL** This Period (last page this line number only)..... ►