Credit Card Authorization

American Association of Public Health Dentistry
3085 Stevenson Drive, Suite 200
Springfield, IL 62703
217-529-6941
217-529-9120 fax

To Our Valued Customers:

Visa and MasterCard have recently changed their procedures for processing credit cards over the telephone and by mail. To insure that we are in compliance we must have this receipt signed, authorizing use of your credit card for purchases. We must be able to produce this document when requested by the processor. Your personal, identifiable, information will be kept confidential and stored in a secure environment.

If you have any questions, please do not hesitate to call us at 217-529-6941

Thank you for your continued trust and confidence - We appreciate your business

Company Name: ____

Company Contact: ____

Company Phone Number: ____

I, ____________________________ , allow the following total balance charged to our credit card:

Authorized Signature: ____

Total Charged: $____________

Email (for receipt): _____________________________________

Credit Card Information

Card Type (Circle One): VISA MasterCard

Card Number: __ __ __ __- __ __ __ __- __ __ __ __- __ __ __ __

Expiration Date: __ __ / __ __ (MM/YY)

CVV2#: __ __ __ (last three digits in the signature line on the back of the credit card)

Name (On Card): ____

Address (relating to card owner): ____

City / State / Zip: ____

Phone: ____________________________________

Please fax form to Sandi Steil c/o AAPHD at (217) 529-9120