

Credit Card Authorization

American Association of Public Health Dentistry
136 Everett Rd.
Albany, NY 12205
217-529-6941

To Our Valued Customers:

Visa, MasterCard, and Discover have recently changed their procedures for processing credit cards over the telephone and by mail. To ensure 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

Cardholder Company/Organization Name: _____

Cardholder Company/Organization Contact: _____

Cardholder Company/Organization 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):   

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 return to info@aaphd.org