PHARMACORR STERILE

Credit Card Billing Authorization Form

Company Name:

Person Authorizing:

Credit Card Type: visa ○ MasterCard ○ Amex ◉ Discover ○

If other please specify:

Issuing Bank:

Name on the Card:

Credit Card Number:

CVC Number (back of card):

Expiration Date:

Billing Address:

City:

State/Province:

Zip/Postal Code:

Country:

Phone Number:

Fax Number:

Applicant agrees that all information provided is accurate and complete. Applicant also acknowledges that all orders may be immediately terminated at the discretion of Medivant Healthcare if any charges are declined or charge backs are claimed against any outstanding invoiced amount.

The undersigned is the duly authorized representative of the company as stated above.

Authorized Signature: **Date:**