USA Mobile Drug Testing of the Treasure Coast

CREDIT CARD AUTHORIZATION FORM

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| **Instructions**   1. Please complete this form by printing, legibly with a dark pen. 2. Sign with the credit card holder’s signature on the line indicated. 3. Include a photocopy of the front and back of the signed credit card. 4. Fax this form and the photocopy of the signed credit card to our secure fax machine at **772-679-0122**. |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Credit Card Type:** |  | VISA |  | MasterCard |  | Discover |  | American Express |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Credit Card Number:** |  |  |  |  |  |  |  |  |  |  |  | **Security Number (back):** |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Expiration Date:** |  |  |  |  |

**M M Y Y**

**Credit Card Billing Address:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Street** |  | **City** |  |
| **State** |  | **Zip** |  |

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| **I, the undersigned, acknowledge that I am the authorized user of this credit card and I hereby authorize USAMDT to charge my credit card in the amount of:**  **WRITE DOLLAR AMOUNT (Numbers)**  **PRINT DOLLAR AMOUNT (Words)**  **By signing this authorization I acknowledge that I have read and agreed to all of the above information and warrant all information provided is true and correct.**  **Card Holder’s Printed Name**  **Card Holder’s Signature Date** |

*Revised 7-11-13*