CLIENT CREDIT CARD AUTHORIZATION

CLIENT NAME: ____

BUSINESS NAME: ____

CARDHOLDER NAME: _______________________________________

BILLING ADDRESS(including zip code):

____

____

____

CARD NUMBER: ____

EXPIRATION DATE: __________________

CVV# (3 digit security # on back of card in signature panel): ___________

AMOUNT TO BE CHARGED: _____________

AUTHORIZED USERS: __________________________

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I AUTHORIZE THE BREVARD COUNTY HEALTH DEPARTMENT TO CHARGE THE ABOVE CREDIT CARD AT THE REQUEST OF THE CARDHOLDER OR ANY OF THE AUTHORIZED USERS LISTED ABOVE.

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CARDHOLDER SIGNATURE DATE

HD-32E(rev 3-07)