



## Authorization for the Union County General Health District to receive payment by Visa/MasterCard

UCHD employee \_\_\_\_\_ Date \_\_\_\_\_

Cardholder's name \_\_\_\_\_

Cardholder's address \_\_\_\_\_

Cardholder's telephone number \_\_\_\_\_

Cardholder's facsimile number \_\_\_\_\_

Driver's license number \_\_\_\_\_

Credit card number \_\_\_\_\_

Credit card type    MasterCard             Visa             Attach a copy of the sales slip.

CV code (3-digit code on back on card) \_\_\_\_\_

Expiration date \_\_\_\_ / \_\_\_\_    Amount authorized \$ \_\_\_\_\_

Transaction authorization number \_\_\_\_\_

By signing below, you indicate you have read and understand the above written information and fully understand that by signing this form you are authorizing the Union County General Health District to charge your credit/ debit card for payment upon your request in person or by telephone.

\_\_\_\_\_

Signature of cardholder

\_\_\_\_\_

Date

**Confidentiality Notice**

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Thank you.