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

This message is intended only for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and prohibited from redisclosure under applicable law. If the reader of this notice is not the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone and return these papers to us at the address shown above via first class mail.

Thank you.