



Credit Card Authorization Form

In order for AVSC to process your credit card payment, please complete the following information:

Date: _____ Customer #: _____

Hospital Name: _____

Credit Card Holder's Name : _____

Credit Card Holder's Address: _____

Credit Card Type: Visa Mastercard Discover Amex

Credit Card No: _____

Expiration Date : _____ Security Code: * _____

I agree to have the above credit card charges per order placed with AVSC

* Last 3 digits on signature panel - Amex front of card

Signature : _____

If you would prefer to be placed on our monthly automatic credit card payment system, please authorize by signing customer approval and circle date you prefer: 5th or 15th

Customer Approval : _____

PLEASE FAX TO 631.389.2536 - Thank You.