



CREDIT CARD AUTHORIZATION FORM

I, _____, hereby authorize *Specialty Health Education Inc.* to charge my credit card account in the amount of: \$_____ for goods and/or services.

Visa  MasterCard 

Credit Card Number: _____

Expiration Date: ____ / ____ Security Code: _____ (from back of card)

Hospital Name (if using hospital card): _____

Credit Card Billing Address:

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (_____) _____ - _____

Requested Shipping Address (If different from Billing Address):

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (_____) _____ - _____

X _____
Cardholder's Signature **Date**

Your completion of this authorization form helps us to protect you, from credit card fraud. *Specialty Health Education, Inc.* will keep all information entered on this form strictly confidential.

**Fax completed form to *Specialty Health Education, Inc.* at (610) 630-6676.
Your Order or Registration will be processed upon receipt of this completed form.**