Connecticut Association of Health Care Facilities, Inc.
111 Founders Plaza, Suite 1002
East Hartford, CT 06108
(860) 290-9424 (860) 290-9478

Credit Card Authorization Form

Please complete the form and fax it to us at (860) 290-9478

Name: _____

Company/Facility _____

Address: _____

_____

City, State, Zip: _____

Phone: _____

Email Address: _____

Billing Address (if different):

Company/Facility _____

Address: _____

_____

City, State, Zip: _____

Phone: _____

Credit Card Information:

Type of Card: _____

Credit Card Number: _____
Expiration Date:
Example: 06/08 _____
3 digit security code (on back)

4 digit security code (American
Express only, on front) _____

Amount to Charge: _____

Reason for Charge: _____

I agree to pay above total amount according to card issuer agreement.

Signature: _____

Print Name: _____