Connecticut Association of Health Care Facilities, Inc.
213 Court Street, Suite 202
Middletown, CT 06457
(860) 290-9424 (860) 290-9478

Credit Card Authorization Form

PCI COMPLIANCE MANDATES THAT THIS FORM MUST BE FAXED - DO NOT EMAIL
FAX NUMBER: (860) 290-9478

Company: _____

Name: _____

Address: _____

City, State, Zip: _____

Telephone: _____

Email Address: _____

Billing Address (if different):

Address: _____

City, State, Zip: _____

Telephone: _____

Credit Card Information:

Type of Card: _____

Credit Card Number: _____

Expiration Date:
Example: 06/20 _____

SECURITY CODE:

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: _____