



# JAMES

*Keeping Members Informed*

## CREDIT CARD PAYMENT AUTHORIZATION FORM

I, \_\_\_\_\_, authorize the  
Cardholder Name  
Jersey Association of Medical Equipment Services to charge my credit card for  
\_\_\_\_\_ on or after \_\_\_\_\_.  
Dollar Amount Date

If this authorization is valid for more than one date, please specify the intervals the charge will be allowed for:

Quarterly  
 Semi-Annual  
 Other: \_\_\_\_\_

Visa  
 Mastercard  
 American Express

Cardholder Name: \_\_\_\_\_  
Company: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Credit Card Number: \_\_\_\_\_  
Security Code: \_\_\_\_\_ Expiration Date: \_\_\_\_\_  
Authorized Signature: \_\_\_\_\_