CREDIT CARD AUTHORIZATION FOR ABGD OUTCOMES ASSESSMENT EXAM

Please use ink and print clearly in BLOCK CAPITAL LETTERS!

Program Number

Institutional Name on Order Form

Program Director

First Name

Last Name

Name on Credit Card

Billing address (as it appears on the credit card statement)

Street Address

Suite/Apt. #

City

State

Zip Code

.

Expiration Date

M M / Y Y

Credit Card number (do not use spaces or dashes)

Security Code

I authorize the charge of (enter amount in whole numbers)

Type of credit card: VISA ☐ Master Card ☐

Amount entered on your Outcomes Assessment Order Form for Credit Card payment $ ________________
(This amount must match the amount entered in the boxes above.)

Telephone where we can contact you regarding the above transaction

Phone (area code first)

Alternate Phone (area code first)

I affirm that the information I have provided in this form is correct and I authorize the American Board of General Dentistry to proceed with the above credit card charge.

_______________________________________ _______________________________

Authorized Signature

Date

Please return by email to assistantabgd@tampabay.rr.com or via fax at 727-683-9326.