Credit Card Authorization Form

Please complete the form and return it
THE APOTHECARY AT WARDENBURG HEALTH CENTER
or
apothecary@colorado.edu
All information will remain confidential.

Cardholder Name: _____

Billing Address: _____

_____

Credit card type: ____ Visa ____ Mastercard ____ Discover ____ American Express

Credit card number: _____

Expiration Date: _____

Card identification number (last 3 digits located on the back of the credit card) _____

Amount to Charge: $ _____ (USD)

I authorize The Apothecary at Wardenburg Health Center to charge the agreed upon dollar amount listed above to my credit card provided herein. I agree that I will pay for this purchase in accordance with the issuing bank cardholder agreement.

Cardholder - Print name, sign and date below:

Printed name: _____ Date: _____

Signed name: _____

Return the completed form to:
The Apothecary at Wardenburh Health Center
Fax Number 303.492.4874; Phone Number 303.492.8553
E-mail -Apothecary@colorado.edu

University of Colorado
The Apothecary at Wardenburg Health Center
UCB 119
Boulder, CO 80309