# Norfolk Allied Health Training Center

## Credit Card Authorization Form One-Time

### CARDHOLDER INFORMATION

Name:___________________________________________________________

Billing Street Address:_______________________________________________

Street Address (cont.):_______________________________________________

City:____________________ State:_________ Postal Code:_______________

Country:_________________________ Email _________________________

Address:_______________________________________________________

Direct Telephone: (___)______-__________

### INFORMATION

Purpose:_______________________________________________________

☐ I authorize a one-time charge against my credit card for the follow amount $_____

☐ I authorize a recurring charge against my credit card for the following amount

$____________ once every ______ day(s)/week(s)/month(s)/year(s) beginning

_______/_______/_______ and ending after_____ payments.

### CREDIT CARD INFORMATION

Credit Card Type: ☐ MasterCard ☐ Visa ☐ American Express ☐ Discover Card

Number:_______________________________________________________

Expiration Month:_____ Expiration Year:_____

Cardholder Signature X_________________________ Date__/___/___

Security Code:_____________

533 East Little Creek Suite C, Norfolk, VA 23505