Quality of Life for Families XXVI: *Caring and Keeping Our Patients* Caregivers Safe

Authorization for Credit Card Use

COMPLETE THIS AUTHORIZATION FORM AND RETURN.
All information will remain confidential

*Name on Card: ______________________________

*Email Address: ______________________________

Billing Address (Optional) ______________________________

*Credit Card Type: _____ Visa _____ Mastercard ____ Discover _____ AmEx

*Credit Card Number: ______________________________

*Expiration Date: ______________________________

*Amount to Charge: $ _______________ (USD)

Please note that there will be a 2.5% additional credit card use charge.

I authorize **PAC/LAC** to charge the amount listed above to the credit card provided herein. I agree to pay for this purchase in accordance with the issuing bank cardholder agreement.
Cardholder – Please Sign and Date

Signature: ______________________________

Date: ______________________________

Print Name: ______________________________

Return the completed and signed form to the following:

Aida Simonian at asimonian@paclac.org