

CREDIT CARD AUTHORIZATION

Name: _____

Address: _____

City: _____ State _____ Zip _____

Daytime Phone#: _____

Visa/MC#: _____

Expiration Date: _____

Name As It Appears On Card: _____

Amount Being Charged: _____

I AUTHORIZE THE UNIVERSITY OF EAST-WEST MEDICINE TO CHARGE MY
CREDIT CARD FOR THE AMOUNT ABOVE

Signature

Date

You may fax the completed form to: (408) 992-0448
If you have any question please call: (408) 738-9888