Credit Card Authorization Form

PLEASE COMPLETE THIS AUTHORIZATION AND RETURN IT TO US.

All information will remain confidential.

Cardholder Name: _____

Credit Card Type:

☐ Visa ☐ Mastercard ☐ American Express (a 1% surcharge will be applied to all AmEx payments)

Credit Card Number: _____

Expiration Date: _____

Charge Amount: $ _____ (USD)

I authorize **Global Dental Relief** to charge the 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:

Signed: _____

Dated: _____

Name: _____

Once signed please return the completed form to:

Global Dental Relief

info@globaldentalrelief.org

4105 E Florida Ave., Ste. 200

Denver, CO 80222

USA