CREDIT CARD AUTHORIZATION FORM

Belize Campus: Sea Grape Drive ◆ San Pedro Town, Ambergris Caye, Belize **U.S. MAILING ADDRESS:** 2602 Oakstone Drive, Suite 6 ◆ Columbus, OH 43231

Phone: 1-866-966-29843 ◆ Fax: 1-614-340-4688 ◆ Email: admissions@wuhs.org ◆ Website: www.wuhs.org

Washington University of Health and Sciences

Your completion of this authorization helps us to protect you from credit card fraud. All information entered on this form will be kept strictly confidential. Please print out, complete this authorization form and return it to the Finance Department for processing. I authorize the charges to the credit card by signing below.

ST	STUDENT INFORMATION																														
1	Studen	Student Name:																													
					Last/Family Name/Surname											First/Given/Personal					Middle										
<u>2</u>	Studen	tudent ID Number: Current Enrollment:																													
	- HO		1015			арреа	rs on I	D card	rd									Program - Semester													
CA	RD HO	LDEK	INF	ORM	ATION					I							1														
3	Name:																														
			List n	ame e	xactly ho	xactly how it appears on card (leave space in between names where necessary))		•											
4 Address:																															
<u> </u>	Auures	э.		Nu	mber and s	per and street or rural route as appears on							n credit card statement				Apt. No. Area Code				Phone Number										
										State				Country					Zip Code												
STUDENT INFORMATION CREDIT CARD INFORMATION																															
	-				ard payme credit/deb				-	of 4%	of the	amoui	nt being pro	cessed	l. All si	tudent	s must	have (a signe	d form	on file in	the									
	Credit	-		_	•																										
Expiration Date Card Code* Card Type																															
U U U U U U U VISA MC AMEX DISCOVER														₹																	
	Authorized Amount (.03 will be added) Student email address:																														
*three digit code on back of card																															
I AGREE TO PAY ABOVE AMOUNT ACCORDING TO CARD ISSUER AGREEMENT Being the cardholder, by signing below I understand and agree to pay, and specifically authorize Med Serve International to charge the credit card account for the university services provided. I have received and accept the current charges and credits applied to student's account. I further agree that in the event this credit card payment becomes declined, I will provide the WUHS Finance Department with new valid credit card information upon request, to be charged for any outstanding balances owed by the student to Washington University of Health and Sciences. *By Signing, student authorizes the above credit card transaction to be complete in accordance with Payment Plan Designation																															
Sigi	nature: _														Date	e:					nature: Date:										