



# Credit Card Authorization Form

In order to ensure that orders get processed in a timely manner, please complete this form and return to College Pharmacy via fax (800-556-5893), or email (customerservice@collegepharmacy.com), along with a copy of the cardholder's ID, and a copy of the front and back of the credit card.

## BILLING INFORMATION:

Name on Card: \_\_\_\_\_

Billing Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

Credit Card Type:  Visa  Mastercard  AmEx  Discover

Credit Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Items Purchased:  OTC Product(s)  
 Compounded Prescription(s)  
 Medical Device

Amount to Charge: \$ \_\_\_\_\_

I authorize College Pharmacy 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: \_\_\_\_\_

**Please send completed form, along with a scan of the front and back of the credit card and a copy of the cardholder's ID to us by fax or email**