

CHARGE CARD AUTHORIZATION PAYMENT

FROM: Lan Tran 206-616-4057
RE: Credit card payment
E-MAIL TO: billing@uw.edu

DATE: _____

FAX TO: 1-206-685-4865

I _____ hereby authorize UW Dept. of Comparative Medicine
to charge \$ _____ against my credit card on about _____ / _____ / _____
Month / day / year

VISA _____ MC _____ Acct. # _____ XXXX-XXXX-XXXX-
(Provide only the last 4 digits of your card and call in the rest)

Exp. Date: _____ **Digit Security Code:** _____

NAME AS IT APPEARS ON THE CREDIT CARD: _____
(Card holders name here)

CREDIT CARD BILLING ADDRESS:

Street (including suite #) city state zip

'Eqw ev<*Rj qpg'tpf 'Go chw' _____ aaaaaaaaa.

This is to be paid to University of Washington Dept. of Comparative Medicine.

Signature: _____

Date: _____

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