TOBERMORY HEALTH SERVICES AUXILIARY

CANADIAN REGISTERED CHARITY # 81025 3609 RR0001

Credit Card Billing Information		
Name On Card		
Credit Card Type	❑ Visa ❑ Master Card	
Person Authorizing		
Credit card Number		
CVC Number	(last 3 digits on back of card)	
Expiry Date		
Billing Address		
City		
Province		
Postal Code		
Country		
Phone Number		
Email Address		
Please select one of the following Payment Options:		
Once	Bill my credit **once** for the following amount.	$ _____
Monthly	Bill my credit card once per month for $ _____ for ____ months	TOTAL MOUNT _____
Applicant agrees that all information provided is accurate and complete. Disputes to amounts invoiced should be immediately reported to Tobermory Health Services Auxiliary. Changes in the status of this card should be reported to Tobermory Health Services Auxiliary.		

Authorized Signature: _____ Date: _____

P.O. Box 241 · 7275 Highway #6 · Tobermory · ON · N0H 2R0