Credit Card Authorization Form

Name as it appears on the Card: _____

Type of Card: Visa ☐ MC ☐ AmEx ☐ Discover ☐

Other ☐ _____

Credit/Debit Card Number _____

Expiration Date _____

Security Code _____

Billing Address _____

City, State, Zip _____

Phone Number _____

Relationship to Student _____

Student ID # _____

Student Name _____

Dates of Charges _____

_____

_____

Authorized Amount _____

By signing this form, I authorize Brockton Hospital School of Nursing **to charge my card for the amount listed above. I certify that all information above is complete and accurate. I certify that I am the authorized holder and signer of the credit card referenced above. I hereby authorize collection of payment for all charges as indicated above. Charges may not exceed the amount listed above in the "Authorized Amount" field. I understand that this is only for up to this amount during the time period of "Dates of Charges" referenced above. If additional charges are going to be authorized, a new form will have to be completed.**

Signed: _____ Date: _____