

New Jersey School of Dental Assisting Credit Card Authorization Form

I, _____, authorize New Jersey School of Dental Assisting to charge to the following credit card account in the amount shown below for the following services and at the following frequency:

CREDIT CARD INFORMATION:

Today's Date:	
Credit Card Type (Visa, Mastercard or American Express)	
Credit Card Number (16 digits for Visa & Mastercard) (15 digits for American Express)	
Credit Card Expiration Date (dd/mm/yyyy format)	
Credit Card Security Code (located on the back of the card)	
Full Name as Shown on Credit Card	
Complete Billing Address	
E-mail address to send receipt	
Amount to be Charged	
Cardholder's Printed Name	
Cardholder's Signature	

NJ School of Dental Assisting, Inc.

Billing Office

15 Wellington Lane

Lakewood, NJ 08701

Tel: 800-726-2137 ext 3 Fax: 888-780-6972 Email: lsw@optonline.net