LUV MEDICAL *Controlled Environment Supplier*

Payment Authorization Form

Must be completely filled out before order is shipped
Send completed form by e-mail or Fax

SECTION I.

Company Name: _____

Billing Address (Complete only if different from ship to address)**:** **P.O. #:** _____

_____

_____

SECTION II.

Credit Card Type:

☐ VISA ☐ MasterCard ☐ American Express ☐ Discover

Card Number: _____ **Expire:** _____

Card Code Verification (3 or 4 digit # on card)**:** _____

Authorization

I authorize LuvMedical to charge the above credit card the appropriate amount for order(s) placed with your company. My electronic signature also indicates that I understand and agree to the Terms and Conditions of sale as stated under a separate cover.

Card Holder Name: (Type) _____ **Date:** _____

PLEASE NOTE: LUV MEDICAL WILL NOT MAINTAIN CUSTOMER PAYMENT INFORMATION IN ITS FILES. THIS DOCUMENT WILL BE DESTROYED ONCE CUSTOMER'S CREDIT CARD HAS BEEN BILLED FOR PAYMENT OF AN ORDER.