Data Surgeon Inc.
18529 Chemawa LN NE, Silverton, OR 97381
Telephone: (503) 333-4635
E-Mail: surgeon@datasurgeon.com
Website: datasurgeon.com

CREDIT CARD AUTHORIZATION FORM

I,____, authorize Data Surgeon Inc. to charge
CARDHOLDER NAME

$50 Evaluation Fee and:

$________________to my credit card.
DOLLAR AMOUNT

Cardholder acknowledges receipt of goods and/or services in the amount of the Total shown hereon and agrees to perform the obligations set forth in the Cardholders Contract Agreement with the Issuer.

____________________________ ______________
CARDHOLDER SIGNATURE DATE

Credit Card Type (circle one) MasterCard Visa

Credit Card Number: ____Code_______

Expiration Date: _____________

Full Name (as it appears on the card): ____

Company Name (if applicable): ____

Mailing address (billing address for credit card statement) _________________________

____

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Phone:

Fax:

OFFICE USE ONLY