Date: _____

I _____ authorize Dental Assisting Institute to charge

My Credit Card in the amount of $_____ for _____.

I understand that this payment is non-refundable and non-cancellable.

_____
Signature

Credit Card: Visa MC

Complete Credit Card Number: _____

Complete Name of Cardholder: _____

Expiration Date: _____

Security Code: _____

Daytime Phone Number: _____

NOTE: A copy of both sides of the credit card and both sides of the holder's identification card must be submitted. Payments cannot be taken without these two items.

******* Please fax completed form, copy of both sides of Credit Card and both sides of ID Document to 209-661-9005***