509 Paul Morris Dr
Englewood, FL 34223
800-373-5935

CREDIT CARD AUTHORIZATION FORM

VISA/MASTERCARD
DISCOVER/AMERICAN EXPRESS
AUTHORIZATION AGREEMENT

I, _______________________________________, hereby authorize JSB Orthotics and Medical Supply, Inc. to charge my purchases to my credit card. The transaction for the monthly statement balance will occur on the 1st of the month, following the statement date.

ACCOUNT INFORMATION

Account Number: ____ Exp. Date: _______/_______

Issuing Bank____

(Please check) Visa: ☐ MasterCard: ☐ Discover: ☐ American Express: ☐

Names as it appears on the Credit Card____
(Please Print)

____ _______/________/_______________
Authorized Signature Date

Name____

Address____

Address: ___________________________________ City: ___________________ State: ________ Zip: _________

Phone#: (_____)____________________________Email: ____________________@______________________

Fax#: (_____)________________________________

FAX: 888-875-1229 EMAIL: Michele@JSBinc.com