Credit Card Authorization

YOUR INFORMATION

Name: ______________________________

Company: ______________________________

Address: ______________________________

City ______________________ St ____________ Zip ____________

Phone: ______________________ Fax: ______________________

Email: ______________________________

Description of purchase ______________________________

METHOD OF PAYMENT — Credit Card | Check

☐ Visa ☐ Master Card ☐ AMEX ☐ Discover

☐ Check Amount $__________ Check # ____________

Card # ______________________ Exp. Date ________

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Credit Card Signature Authorization

Make check payable to: Clark County Medical Society or CCMS

Billing Address zip code ______________________________

Today's Date ______________________________

Mail to:	Clark County Medical Society 2590 E. Russell Road Las Vegas, Nevada 89120
Fax:	702.739.6345