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# Ajentis Medical Credit Card Authorization Form

COMPANY: \_\_\_\_\_

COMPANY LOCATION: \_\_\_\_\_

DATE: \_\_\_\_\_

FAX NUMBER: \_\_\_\_\_

CREDIT CARD TYPE:     VISA                     MASTERCARD                     AMERICAN EXPRESS  
 please check one

INVOICES TO BE PAID	INVOICE AMOUNT	
	\$	
	\$	
	\$	
	\$	
	\$	
	\$	
	\$	
	\$	
	\$	
	\$	
	\$	
	\$	
<b>TOTAL:</b>	\$	

INTERNAL USE ONLY
TRANSACTION DATE:
AUTHORIZATION #:

CARD NUMBER:	CVC/CVV/CID	EXPIRY DATE:
CARDHOLDERS NAME:	CARDHOLDERS SIGNATURE:	

Should you require any assistance please contact the customer service at 1-866-450-0204.

