



CREDIT CARD AUTHORIZATION FORM

Please complete the information below and send back via email to:
businessmanager.anesthesia@utoronto.ca

CUSTOMER INFORMATION			
Company			
Last Name		First Name	
Address			
City		State/Province	
Zip/Postal Code		Country	
Phone Number			
Email Address			

BILLING INFORMATION <i>(if different from above, billing info must match your credit card statement)</i>			
Company			
Last Name		First Name	
Address			
City		State/Province	
Zip/Postal Code		Country	
Phone Number			
Email Address			

CREDIT CARD INFORMATION			
Card Type (AMEX, VISA, MC)		Exp Date (mm/yyyy)	
Card Number		CVV Code	
Authorized Signature		Total Charge	

Invoice #	
Description	

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