Credit Card Authorization Form

Total Amount to Charge $_____

☐☐ ☐ ☐ - ☐ ☐ ☐ ☐ - ☐ ☐ ☐ ☐ - ☐ ☐ ☐☐

Expiration Date ☐☐ - ☐☐

_____

Signature

_____

Name (As it appears on your credit card)

_____

Address

_____

City State Zip Phone Email

NOTE: Payment must be received at the time you place your ad or reserve your tickets.

Pay online by visiting the following link: www.bronxdocs.org/annual-medical-symposium

or **FAX RESPONSE ALONG WITH CREDIT CARD INFORMATION: 718-744-9014**

Mail Checks Payable to:
Bronx County Medical Society
c/o Ronald Blount,
Executive Director
P.O. Box 740402 Bronx, NY,10474