CREDIT CARD AUTHORIZATION FORM

Caribbean Medical University

Campus: WTC Piscadera Bay, Curacao, Netherlands Antilles • Phone: (5999) 788-0015
Finance Department: 5600 N River Road Suite 800 • Des Plaines, Illinois 60018 United States
Phone: (888) 877-4268 • Fax: (302) 397-2092 • Email: finance@cmumed.org • Web: http://www.cmumed.org

Your completion of this authorization form helps us to protect you from credit card fraud. All information entered on this form will be kept strictly confidential. Please print out, complete this authorization form and return it to the Finance Department by fax, email or regular mail. I authorize the charges to the credit card by signing below.

STUDENT INFORMATION

Student Name:
Last Name *First Name* *Middle Name*

Student ID Number _ _ _ Current Enrollment: —
As appears on ID card *Program - Semester*

CARDHOLDER INFORMATION

Name:
Last Name *First Name* *Middle Name*

Address: ( )
Number and street or rural route *Apt. No.* *Area Code* *Phone Number*

City or Town *State* *Zip Code* *Country*

CREDIT CARD INFORMATION

Credit Card Number

Expiration Date M M Y Y Card Code *

Card Type ☐ Visa ☐ MC ☐ AMEX ☐ Discover

Authorized Amount . (in U.S. dollars)

** three digit code on the back of the card*

AUTHORIZATION

I AGREE TO PAY ABOVE AMOUNT ACCORDING TO CARD ISSUER AGREEMENT

Being the cardholder, by signing below I understand and agree to pay, and specifically authorize Caribbean Medical University to charge the credit card account for the university services provided. I have received and accepted an itemized tuition statement detailing all of the current charges and credits applied to student's account. I further agree that in the event this credit card payment becomes declined, I will provide the CMU Finance Department with new valid credit card information upon request, to be charged for any outstanding balances owed by the student to Caribbean Medical University.

Cardholder's Signature: _____ Date: __ __ / __ __ / __ __

REV. 2/11