



Credit Card Payment Form

ALL INFORMATION MUST BE PROVIDED FOR PROCESSING

Submit to the IOF Accounts Administrator, Evi Rossetti, at erossetti@iofbonehealth.org or fax to +41 22 994 01 01

Name _____

Address _____

Telephone _____

E-mail _____

- I hereby authorize IOF to debit my credit card with the amount shown below
- I hereby agree to pay credit card charges 3% (for payments by Visa & Master Card)
- I hereby agree to pay credit card charges 3.20% (for payments by Amex)

CREDIT CARD INFORMATION

CARD TYPE Visa
 Master Card
 AMEX

CARD NUMBER _____

NAME AS IT APPEARS ON CARD _____

EXPIRATION DATE (MM YY) _____

VERIFICATION CODE _____

PAYMENT INFORMATION

PAYMENT AMOUNT _____

DESCRIPTION _____

Cardholder Signature Location Date

IOF ISCD Course Administrators

NORTH & SOUTH AMERICA Amy Scrivens ascrivens@iscd.org • OTHER REGIONS Ageeth van Leersum-Frikkee avanleersum@iofbonehealth.org