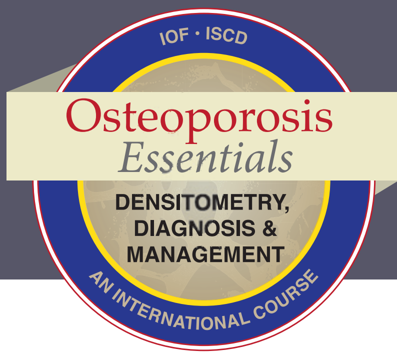


# Credit Card Payment Form

## 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<br>☐ Master Card<br>☐ 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*