



# One Time Credit Card Authorization Form

By signing this form you give The American Board of Nuclear Medicine permission to debit your account for the amount indicated on or after the indicated date. This is permission for a single transaction only, and does not provide authorization for any additional unrelated debits or credits to your account. This form is to be treated as confidential when filled out. **All fields MUST be completed and accurate based on credit card issued or transaction cannot be processed.**

## Request Type/Information

Request Type <input type="text"/>	Requested By (contact name) <input type="text"/>
Description of Request and Payment Information <input type="text"/>	Company (if applicable) <input type="text"/>
	Address <input type="text"/>
	City <input type="text"/> State/Province/Region <input type="text"/>
	Zip Code + 4 <input type="text"/> Country <input type="text"/>
	Email Address <input type="text"/>

## Credit Card/Payment Information

Telephone Number <input type="text"/>	Email Address <input type="text"/>
Credit Card Type <input type="text"/>	Cardholder Name (as it appears on credit card) <input type="text"/>
	Credit Card Billing Address <input type="text"/>
Credit Card# <input type="text"/>	<input type="text"/>
Expiration Date <input type="text"/> / <input type="text"/>	City <input type="text"/> State/Province/Region <input type="text"/>
CVV/CVC/CID Code <input type="text"/>	Zip Code + 4 <input type="text"/> Country <input type="text"/>

Visa®, MasterCard® and Discover® cardholders: Turn your card over and look at the signature box. You should see either the entire 16-digit credit card number or just the last four digits followed by a special 3-digit code. This 3-digit code is your CVW number / Card Security Code.

American Express® cardholders: Look for the 4-digit code printed on the front of your card just above and to the right of your main credit card number. This 4-digit code is your Card Identification Number (CID). The CID is the four-digit code printed just above the Account Number

Amount To Be Charged to Credit Card (in U.S. Dollars)

Authorized Cardholder's Signature  Date

I authorize the American Board of Nuclear Medicine to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for goods/services described above, for the amount indicated above only and is valid for one time use only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company so long as the transaction corresponds to the terms indicated in this form.

**Please complete, print, SIGN AND SCAN (signature must be included). Email form to: [abnm@abnm.org](mailto:abnm@abnm.org)**

**OR**

**Complete, print, and sign form. Mail form via U.S. Postal Mail to:  
American Board of Nuclear Medicine**

**1030 Highlands Plaza Drive, Suite 511E, Saint Louis, Missouri 63110-1343**