DMAZ Corporation
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Credit Card Payment Authorization Form For Health Care Applicants

Complete and sign this form to authorize **DMAZ Corporation** to make a onetime debit to your credit/debit card listed below.

I,_____ authorize **DMAZ Corporation** (an Illinois Corporation) to charge my credit/debit card account indicated below for **$125.99** + **$5.99** Credit Card Fee on or after (date)_____. This payment is for Hard Card Conversion Fingerprint / Livescan Fingerprint Services.

Account Type (circle one): **Visa** **MasterCard** **AMEX** **Discover**

Cardholder Name:_____

Billing Address:_____

City:_____ **State:**_____ **Zip**_____

Card Number:_____

Expiration Date:_____ CVV:_____

Email Address:_____

Phone Number:_____

Signature_____ **Date**_____

I authorize DMAZ Corporation to charge the above mentioned credit/debit card for the above services. The amount indicated above is for a one time transaction only. I certify that I am the authorized user of the credit/debit card mentioned above thus would not dispute the payment with your credit/debit card company so long as the transaction correspond to the terms and agreement stipulated in this form.