Maryland Department of Health
Laboratories Administration

One-Time & Repeat Payments

Credit Card Authorization Form

CARDHOLDER INFORMATION

Name: _____

Billing Street Address: _____

Street Address (cont.): _____

City: _____ State: _____ Postal Code: _____

Country: _____ Email _____

Direct Telephone: _____

Payment Information

Invoice # _____

Customer Code _____

□ I authorize a one-time charge against my credit card for the following amount $ _____

□ I authorize the use of this card for future payments

CREDIT CARD INFORMATION

Credit Card Type: □ MasterCard □ VISA

Number: _____

Expiration Month: _____ Expiration Year: _____ CVV (last 3 digits back of card) _____

Cardholder Signature: _____ Date___/___/___

Please fax or scan& email form with COPY of INVOICE to:

Nicole McDonald @ 443-681-5198 or Email: nicole.mcdonald@maryland.gov
Or Mail: DHMH Laboratories Administration, Nicole McDonald, P.O. Box 2355, Baltimore, MD 21205.