



Florida Atlantic University
Office of Executive Education
Credit Card Payment Form

Program: **EMTP**

Name: _____ SSN#: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Telephone: _____ Office Telephone: _____
 MasterCard Visa Discover Card # _____ Expiration Date: _____
Amount _____ Name on Credit Card: _____

I, the undersigned, understand that I cannot cancel this credit card payment. Furthermore, if any credit card is denied, I must pay the amount listed above plus a \$15.00 transaction fee and a \$50.00 late payment fee with a money order.

Signature _____ Date _____

FOR OFFICE USE ONLY	
Agent _____	Date _____
Source _____	
CC # _____	Auth # _____
Registration Verification _____	
Finance Verification _____	
Finance Stamp _____	
Seminar # _____	