



TRAUMA CENTER ASSOCIATION OF AMERICA

650 Montana Ave Suite A
Las Cruces, NM 88001

COMPLETE AND FAX TO TRACEY
Fax (575) 647-9600

CREDIT CARD AUTHORIZATION FORM

Cardholder's Name _____

(Exactly as appears on the card)

Hospital Name: _____

Billing Address: _____

(Street or P. O. Box)

City, State

Zip Code

Type of Credit Card (circle one):

Visa

MasterCard

Discover

Complete Card Number: _____

Expiration Date: _____

CVV/CVC Number _____

(This is located on the back of the card on the signature line)

I authorize **Trauma Center Association of America** to bill the above listed credit card for \$ _____

I am fully aware that my credit card will be charged for the _____.

Cardholders Signature: _____

For TCAA use only:

Email _____ US Mail _____ Fax _____ File _____

Date: _____ Deposit _____

Confirmation # _____