



Pharmsource, LLC

Value, Experience, Integrity

Customer #: _____

Date: _____

CREDIT CARD AUTHORIZATION FORM

PLEASE FILL IN ALL REQUESTED INFORMATION BELOW.

CARDHOLDERS NAME: _____

COMPANY NAME: _____

CREDIT CARD BILLING ADDRESS: _____

MAILING / SHIP TO ADDRESS: _____

PHONE NUMBER: _____

DRIVER'S LICENSE NUMBER : _____ STATE: _____

CREDIT CARD NUMBER: _____

EXP.DATE: _____ CVV# : _____

EMAIL ADDRESS: _____

I HEREBY AUTHORIZE: PHARMSOURCE, LLC, 123 NEWMAN DRIVE, BRUNSWICK, GA 31520 TO CHARGE MY CREDIT CARD ACCOUNT FOR PRODUCT ORDERED.

I OPT FOR AN ADDITIONAL 1% CONVENIENCE FEE WHEN PAYING WITH CREDIT CARD.

***THE ABOVE AUTHORIZATION IS APPLICABLE FOR USE AT TIME OF DELIVERY**

***THE ABOVE AUTHORIZATION IS APPLICABLE FOR ONE TIME USE ONLY**

***THE ABOVE AUTHORIZATION IS APPLICABLE TO ALL TRANSACTIONS (INCLUDES**

PAYMENT DUE ON 10TH AFTER THE END OF MONTH AND AS NEEDED).

CARD HOLDER'S SIGNATURE: _____ DATE: __/__/__

FAX TO: 912-216-0605 or

EMAIL TO: NANDREWS@PHARMSOURCEWHOLESALE.COM