CREDIT CARD AUTHORISATION FORM

NAME OF CARD HOLDER:_____

CREDIT CARD N°:_____

EXPIRY DATE:_____

CVC CODE:_____ _____

I herewith authorise MediCongress to charge the total amount of:_____**EUR**

REFERENCE*: _____

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**** e.g. name of the congress, participant, registration number, etc…***

DATE: **CARD HOLDER'S SIGNATURE:**

_____ _____

FORM TO BE RETURNED TO ASTRID@MEDICONGRESS.COM
OR BY FAX: +32 9 344 40 10