

**North Pine Enterprises**

73 S. Lavalaside Rd. Blackfoot, ID 83221  
(208)785-4424 Fax:(208)785-4424  
www.northpineenterprises.com

**CREDIT CARD AUTHORIZATION FORM**

Please fill out the following information and fax to (208) 785-4424:

PHYSICIAN NAME: \_\_\_\_\_  
STATE LICENSE NO.: \_\_\_\_\_  
SHIPPING ADDRESS: \_\_\_\_\_  
\_\_\_\_\_  
CITY,STATE,ZIP: \_\_\_\_\_  
MAIN PHONE NO.: \_\_\_\_\_  
FAX NO: \_\_\_\_\_  
EMAIL: \_\_\_\_\_  
CONTROLLER/  
ACCOUNT PAYABLE: \_\_\_\_\_  
DIRECT PHONE NO.: \_\_\_\_\_

**CREDIT CARD INFORMATION:**

CARDHOLDER NAME: \_\_\_\_\_  
BILLING ADDRESS: \_\_\_\_\_  
\_\_\_\_\_  
CITY,STATE,ZIP: \_\_\_\_\_  
PHONE NO.: \_\_\_\_\_  
CREDIT CARD TYPE:  Visa  Master Card  Discover  
CREDIT CARD NUMBER: \_\_\_\_\_ EXP. DATE: \_\_\_\_\_  
CC VERIFICATION NO.: \_\_\_\_\_  
(last 3 digits located on back of credit card)

**AUTHORIZATION:**

I, the undersigned, authorize *North Pine Enterprises* to charge the above credit card for the product and quantities listed below:

Item	Quantity	Cost	Total
<i>Derma-Cauter-All Complete Kit</i>		\$260.00	
Shipping and Handling (USPS)			\$20.00
Sales tax 6% (applicable to Idaho Residents)			
Total Charge			

Cardholder Signature: \_\_\_\_\_

Date: \_\_\_\_\_