



**PLEASE RETURN VIA FAX DIRECTLY TO THE CREDIT DEPT.:**

**626.934.6430**

Date:

Account #:

Customer Name:

Please accept this letter as authorization to charge my **VISA/MASTERCARD**:

CARD NUMBER: \_\_\_\_\_

EXPIRATION DATE: \_\_\_\_\_

AMOUNT: \$ \_\_\_\_\_ USD

SIGNATURE-CREDIT CARD HOLDER: \_\_\_\_\_

PRINTED FULL NAME-CREDIT CARD HOLDER: \_\_\_\_\_

ADDRESS (MUST MATCH CARD BILLING ADDRESS):

NUMBER/STREET: \_\_\_\_\_

CITY: \_\_\_\_\_

STATE/PROVINCE: \_\_\_\_\_

ZIP CODE/POSTAL CODE: \_\_\_\_\_

TELEPHONE NUMBER: \_\_\_\_\_

***\$100.00 MINIMUM FOR CREDIT CARD PAYMENTS***