

AUTHORISATION FOR CREDIT CARD PAYMENT

Total payment \$

Client Name

Client Code

CREDIT CARD DETAILS

Credit Card Account Number

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Please double check that your number is correct

Please charge my: Mastercard Visa

Expiry Date _____ / _____
Month / Year

Full name of cardholder

Signature of cardholder.....

**Please return completed form by Fax on 64-4 5692742.
Or email to kendons@kendons.co.nz**