



CREDIT CARD AUTHORIZATION FORM

Contact Information

Name _____

Company _____

Address _____

City _____

State _____

Zip Code _____

Telephone _____

Fax _____

Email _____

ACHE/MHEGA Membership Status: current member non-member

Session you are attending:

Credit card information

Name as it appears on credit card: _____

Visa/MC payments please provide card number: _____ - _____ - _____ - _____

Exp. Date ____ / ____

Address associated with credit card: _____

Security Code _____

Email completed form to mihealthcareexecgroupandassoc@gmail.com or fax to MHEGA at 586. 218.4443.

Your credit card information will be shredded once payment has been processed.

CANCELLATION NOTICE: In the event you must cancel your participation, please notify Deb Ellis, MHEGA Administration, via email at mihealthcareexecgroupandassoc@gmail.com or in writing to the above address. An emailed or written cancellation dated or post-marked 14 DAYS PRIOR to the event entitles you to a refund (less a minimum processing fee of \$15.00 or 25% (whichever is greater)). After that date, all fees/credits toward the program are forfeited. *You are encouraged to send a substitute if you cannot attend.*