Institute for Medical Quality

180 Howard Street • Suite 210 • San Francisco, CA 94105
T 415.882.5151 F 415.882.5149 W imq.org

CREDIT CARD PAYMENT FORM

Name of Organization/CME program: _____

Name of person filling out form: _____

Phone number: _____ Email address:_____

We accept: ❑ **Visa** ❑ **Master Card**

Name as it appears on Credit Card:

Billing Address:

Address:	
City:	
State, Zip:	

Credit Card number:

				-					-					-				

Card Code ***(3 digit code on back of card)***

Expiration Date

Month/Year

Amount to be charged: _____

Check the amount authorized to be charged:

- ◯ $415 Early Bird Registration Fee
- ◯ $445 Registration Fee (after 10/1/2018)
- ◯ $300 Group Discount (10 or more only)
- ◯ $500 Walk-in Registration Fee

By signing below, I agree to the fees charged to the card indicated.

_____ _____

Authorized Signature **Date**

*****

For IMQ Staff: Date charged _____Inv.#_____ Amount $_____ Initials _____