



Credit Card Payment Form

Billing Information

Name: _____ Date: _____

Address Line 1: _____

Address Line 2: _____

City,State: _____ Zip: _____

E-mail: _____ Phone: _____

Credit Card Information

Credit Card Type

Visa
 Mastercard
 Discover
 American Express

Name on Card: _____

Credit Card Number: _____

Expiration Date: _____

Security Code: _____ Amount: _____

Office Use Only

Invoice Information

Vendor ID: _____

Invoice Number: _____

Description: _____

Checklist

Entered Into CC Deposit Spreadsheet	Date: _____	Your Initials: _____
Payment Processed	Date: _____	Your initials: _____
Posted in iMIS	Date: _____	Your initials: _____

Please send form to the Society for Academic Emergency Medicine:

By Mail: SAEM
 2340 S. River Road
 Suite 208
 Des Plaines, IL 60018

By E-mail: membership@saem.org
 By Fax: 847-813-5450