School of Diagnostic Medical Sonography

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One Time Credit Card Payment Authorization Form

Sign and complete this form to authorize the UWHC School of Diagnostic Medical Sonography to make a one-time debit to your credit card listed below.

By signing this form you give us permission to debit your account for the amount indicated on or after the indicated date. This is permission for a single transaction only, and does not provide authorization for any additional unrelated debits or credits to your account.

Please complete the information below:

In payment of the *application fee* for the 2023-2025 class of the UWHC School of Diagnostic Medical Sonography, I _____ (full name) authorize the University of Wisconsin Hospitals and Clinics School of Diagnostic Medical Sonography to charge my credit card account indicated below for _____ (amount) on or after _____ (date).

Billing Address _____ Phone# _____

City, State, Zip _____ Email _____

Account Type: ☐ Visa ☐ MasterCard ☐ AMEX ☐ Discover

Cardholder Name _____

Account Number (*16-digit card number*) _____

Expiration Date _____

CVV2 (3-digit number on back of Visa/MC, 4 digits on front of AMEX) _____

SIGNATURE _____ DATE _____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above, for the amount indicated above only, and is valid for one time use only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

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Attention UWHC Fiscal: Apply to account 593190, cost center 1006480.