Chicago Medical Society (CMS)

Joint Providership Credit Card Authorization

Name of Applying Organization (Joint Provider):

Date of CME Activity:

Title of CME Activity:

Payment & Cardholder Information

Cardholder Name:

Credit Card Type: ☐ Visa ☐ MasterCard ☐ AMEX ☐ Discover

Amount Charged

Card Number: Exp. Date:

Billing Address:

City: State: Zip:

Phone: Fax :

E-mail:

Charges to Include (please check all that apply):

- ☐ CME Application Fee
- ☐ Non-Member Certificate Fee
- ☐ Other (describe):

I am irrevocably authorizing the Chicago Medical Society to charge my credit card, as mentioned above, for the charges incurred by the CME Application. CMS will run a credit card authorization for the estimated amount of charges immediately upon receipt of the CME application.

_____ _____

Cardholder Signature Date

_____ _____

Received by CMS Representative Date

For CMS Use Only:

Authorized Amount: $_____ Authorization Approval Code: _____