GEORGIA DEPARTMENT OF PUBLIC HEALTH
Clayton County Health District

Clayton County Health District
ENVIRONMENTAL HEALTH SERVICES

Credit Card Authorization Form

Please complete this authorization form in its entirety. Incomplete forms cannot be properly processed.
PLEASE PRINT LEGIBLY.

Payment Reference:

Type: ☐ Facility Name ☐ Permit Number ☐ Invoice Number ☐ Parcel ID
Information (Name / Number): _____

Fee Payment To Be Charged: $_____

Card Type: ☐ Visa ☐ MasterCard ☐ Discover

Cardholder Name (Print): _____

Card Number: _____

Exp. Date (MM/YY): _____

Billing Address: _____

_____

_____

Email Address Associated with Billing: _____

By signing this form, I authorize **Clayton County Health District** to charge the credit card indicated in this authorization form. This payment authorization is for the amount indicated above 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. I understand that the payment is non-refundable.

Cardholder/Authorized User's Name (Print): _____

Cardholder / Authorized User's Signature: _____ Date: _____

Cardholder Phone Number: _____