



CREDIT CARD AUTHORISATION FORM

NAME OF CARD HOLDER: _____

CREDIT CARD N°: _____

EXPIRY DATE: _____

CVC CODE: _____

I herewith authorise MediCongress to charge the total amount of: _____ EUR

REFERENCE*: _____

** e.g. name of the congress, participant, registration number, etc...*

DATE:

CARD HOLDER'S SIGNATURE:

FORM TO BE RETURNED TO ASTRID@MEDICONGRESS.COM
OR BY FAX: +32 9 344 40 10