M.D. Stetson Company, Inc.
92 York Avenue
P.O. Box 259
Randolph, MA 02368

TEL: 781-986-6161
800-255-8651
FAX: 781-961-1764
www.mdstetson.com

CREDIT CARD AUTHORIZATION

I affirm that all information provided is accurate and complete. I understand that all orders may be immediately terminated at M.D. Stetson's discretion if any charges are declined or charge backs are claimed against any outstanding invoiced amount. I agree to be liable for all late fees and collection costs. This includes attorney fees as well as all other court costs. Disputes to amounts invoiced should immediately be reported to karen.chace@mdstetson.com

Signature of Corporate Officer or Owner ____ Date ____________

Print Name ____ Title ________________________

Company Name: ____ TEL (____) ________________

Billing Address: _________________________________ City _______________ State ____ Zip _________

Shipping Address: ________________________________ City _______________ State ____ Zip _________

Owner/Manager ____ Title ___________________________

A/P Contact: _____________________ TEL (___) _____________ FAX (___) _______________

Type of Business: _____________________________________ Date Established: _____________________

Type of Entity: ❒ Proprietorship ❒ Partnership ❒ Corporation ❒ Other. _________________________

If Incorporated: State of incorporation ________________________________ Year of Incorporation: __________

Tax Exempt: ❒ No ❒ Yes Number. ________________ **Tax Exempt Certificate must accompany application.**

Credit Card Information

Type of Credit Card ❒ VISA ❒ Mastercard ❒ American Express

Name (as appears on card): ____ Expiration Date: ____________

Credit Card Number: ___________________________________ CVC Number/Security Code: ____________

Credit Card Billing Street Address: ____

City ____ State ________________ Zip ____________

As the credit card holder, I authorize M.D. Stetson Company to keep my credit card information on file. I also authorize M.D. Stetson Company to charge my credit card for future purchases approved by me either verbally or in writing. M.D. Stetson Company will keep all information entered on this form strictly confidential.

Changes in the status of this card can also be reported to karen.chace@mdstetson.com.

Cardholder signature: ______________________________________ Date: ___________________________