

GOODTIME MEDICAL CREDIT CARD FORM

I hereby authorize Goodtime Medical to charge to my credit card \$ _____

.....
Company Name: _____

Address: _____

City/State/Zip: _____

Daytime Phone: _____ Evening Phone: _____

Card Type: (check one) VISA _____ MASTERCARD _____ AMEX _____

Card Number: _____

Name Listed On Credit Card: _____

Expiration date: _____

By signing below, cardholder acknowledges receipt of services described above, on the invoice this payment satisfies and in the terms and conditions at www.examttables.com/shipping-returns.html in the amount of the total shown herein and agrees to perform the obligations set forth in the Cardholder's agreement with the issuer.

Cardholder Signature: _____

Date: _____

Please return completed form to:

Goodtime Medical
25 Cooperative Way
Wright City, MO 63390

Phone: 636-745-7530

Fax: 636-745-7536

.....
Office use only

NTS _____

AP _____

GBOK _____