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.examtables.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_____