



2909 Fairgreen Street • Orlando, FL 32725, USA • Tel (321) 319-4870 • Fax (407) 893-9890 • [AAOF@aaoptom.org](mailto:AAOF@aaoptom.org)

## Credit Card Authorization or Recurring Pledge Payment Form

Name \_\_\_\_\_ Member ID# \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

New Pledge \_\_\_\_\_ Recurring Pledge \_\_\_\_\_ Other \_\_\_\_\_

Has authorized by phone a: \_\_\_\_\_ Pledge payment \_\_\_\_\_ Contribution \_\_\_\_\_ Memorial Donation

Please apply funds to: 1) \_\_\_\_\_ % to \_\_\_\_\_

% & FUND CODE

2) \_\_\_\_\_ % to \_\_\_\_\_

% & FUND CODE

Contribution Description Notes \_\_\_\_\_

Contribution Amount (US \$): \_\_\_\_\_

Contribution Frequency: **One time** \_\_\_\_\_ **Monthly** \_\_\_\_\_ **Quarterly** \_\_\_\_\_ **Yearly**

Beginning date for recurring payment: \_\_\_\_\_

**Statement:** *By signing this form I authorize the AAOF to collect the funds designated via credit card from the account designated to the account of the American Academy of Optometry Foundation at the frequency rate designated for the period required as not to exceed the total amount to be paid of: \$\_\_\_\_\_ at which time the agreement becomes void.*

**Authorizing Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Card Type:** **Visa** \_\_\_\_\_ **MasterCard** \_\_\_\_\_ **AMEX** \_\_\_\_\_ **Discover** \_\_\_\_\_

**Card Holders Name:** \_\_\_\_\_

(as it appears on card)

**Card Number** \_\_\_\_\_ **Exp. Date** \_\_\_\_\_

As authorized by (phone/fax /email) to: \_\_\_\_\_

(circle one)

AAOF Staff Member