

CREDIT CARD PAYMENT AUTHORIZATION

Student's full name: _____

Student's student ID: _____

PHONE#: _____ EMAIL: _____

COMMENTS/PURPOSE OF PAYMENT:

Schoolfees for _____ quarter/term

Amount of payment: _____

Directions:

Please fax completed Credit Card Payment Authorization below to:

Attention: Cashiering Services

Fax #: 650-949-7694

Credit card payment authorization by Fax:

Name on Credit card: _____

Credit card number: _____ Expiration: _____

Authorized charge amount: _____

Billing address: _____
Street City State ZIP

Cardholder's signature: _____ Date: _____

Cashier's office use only:

~Post credit card payment to student ID # and mail receipt to student~