FEES (Non-Refundable)
New Permits = $500.00
Full/Limited Service; Transfer of Ownership In/Out of State; or Re-Registration In/Out of State
---
Fed ID # 56-6000725
Pay by Visa, MasterCard, Discover, or American Express only.

NO checks, money orders, or cash accepted. CREDIT CARD ONLY.

2017

APPLICATION FOR REGISTRATION AND PERMIT TO CONDUCT A PHARMACY

Complete and submit to: North Carolina Board of Pharmacy, 6015 Farrington Rd, Suite 201 Chapel Hill, NC 27517. Permits expire December 31st of the year for which it is issued. It shall be unlawful to practice pharmacy more than 60 days after the expiration date without renewing the permit.

Complete electronically, then print, sign, and date where applicable.
DO NOT FAX OR EMAIL APPLICATION.

(Internal Board Use Only)
Permit #:
Batch #:
Date issued:

http://www.ncbop.org
phone 919.246.1050

***** IMPORTANT! READ PROCEDURES SHEET AND CHECKLIST BEFORE COMPLETING THIS APPLICATION *****

Under North Carolina Law, making "false representations or with[holding] material information in connection with securing a license or permit" is grounds for "refus[ing] to grant . . . a license to practice pharmacy." N.C.G.S. § 90-85.38(a)(1). Any license or permit obtained through false representation or with-holding of material information shall be void and of no effect. N.C.G.S. § 90-85.38(c).

ITEM 1. Pharmacy Name and Address (No more than 37 characters per pharmacy name)

Pharmacy Permit #: _____ *(PERMIT NUMBER IS REQUIRED for TRANSFER OF OWNERSHIP or RE-REGISTRATION)*

NABP Pharmacy e-Profile ID Number (if available): _____

Pharmacy Corporate Name (if applicable): _____

Pharmacy DBA Name: _____

Pharmacy Address: _____

City: _____ State: NC Zip: _____

County *(NC Only)*: _____

All voice telephone numbers: _____

Direct phone # for Pharmacist-Manager: _____

FAX number (direct line only): _____

ITEM 2. Application Type (Select one):

◯ ORIGINAL

◯ TRANSFER OF OWNERSHIP*

◯ RE-REGISTRATION*

**FOR TRANSFER OF OWNERSHIP or RE-REGISTRATION, BE SURE TO INCLUDE EFFECTIVE DATE IN ITEM 3 BELOW.*

Opening Date (for original permit only): _____

List days and hours of operation:
Days: _____ Hours: _____

DEA registration number: _____
(Pending DEA # for original application)

ITEM 3. Transfers of ownership or Re-registration: fill in the following items, only at the time of transfer/re-registration ***(Re-registration required for address changes or changes in percentage of ownership between existing partners):***

Former Pharmacy Name: _____ Date of transfer: _____

Name of former Pharmacist-Manager (if changed): _____ Name of former owner: _____

_____ _____
(Signature of Former Pharmacist-Manager) (Signature of Former Owner)

Permission is hereby given for the transfer of this permit to the signators on Certificates A and B on this document.

Former Pharmacy Location: _____ If Re-registration, Eff Date of Relocation: _____

ITEM 4. All applicants fill in the information requested below for all Pharmacists employed in this pharmacy (*attach additional pages if necessary*):

Name & License Number of Pharmacist-Manager: _____ Number of Hours On Duty Per Week: _____

Name & License # of other full-time or relief pharmacist: _____ Number of Hours On Duty Per Week: _____

Name & License # of other full-time or relief pharmacist: _____ Number of Hours On Duty Per Week: _____

Name & License # of other full-time or relief pharmacist: _____ Number of Hours On Duty Per Week: _____

Name of Board-approved PA, NP or, in Health Depts., RN on duty: _____ Number of Hours On Duty Per Week: _____

Name of Board-approved PA, NP or, in Health Depts., RN on duty: _____ Number of Hours On Duty Per Week: _____

Total Hours Open: _____

ITEM 5. Names & registration numbers of technicians or persons who act under pharmacist supervision in the pharmacy:

Technician Name: _____ Technician Registration Number: _____

Technician Name: _____ Technician Registration Number: _____

(List additional technicians on a separate sheet.)

Continued on next page

ITEM 6. Has the Pharmacist-Manager, any staff pharmacist, or any pharmacy technician SINCE THEIR LAST RENEWAL been charged or disciplined by any licensing or permitting authority, federal or state? Discipline includes, but is not limited to, any letter of warning, reprimand, license suspension or revocation, permit suspension or revocation, or registration suspension or revocation.

(Yes/No) _____ **If yes, please provide the Board with appropriate documentation, including but not limited to the charging document and any disposition of the charge.**

ITEM 7. Pharmacy services provided *(must also complete PHARMACY SERVICES AFFIDAVIT that follows this application):*

A. Are you requesting a Limited Service permit? *(Yes/No)* _____

IF YES, indicate the number of hours that the Pharmacist-Manager will be (physically) present at the site *(REQUIRED):* _____

Is the number of hours you indicated above *WEEKLY* or *MONTHLY*? _____

If a Limited Service permit is requested, an attachment in writing is required. Explain in detail why a Limited Service permit is needed. Include a detailed description of what the site will be dispensing and/or services that will be provided.

B. Does this pharmacy compound? *(Yes/No)* _____

C. Does this pharmacy engage in non-sterile compounding? *(Yes/No)* _____

Does this pharmacy engage in sterile compounding? *(Yes/No)* _____

If "yes," per USP 797 standards, does the pharmacy engage in: Low-risk sterile compounding? *(Yes/No)* _____

Risk Level Guidance Document may be found here.

Medium-risk sterile compounding? *(Yes/No)* _____

High-risk sterile compounding? *(Yes/No)* _____

D. The pharmacist-manager is knowledgeable in the specialized functions of preparing, labeling, and dispensing compounded drug preparations. *See Rule 21 NCAC 46.2801(g) - COMPOUNDING. (Yes/No)* _____

If no, the pharmacist-manager designates the following pharmacist as knowledgeable in the specialized functions of preparing, labeling, and dispensing compounded drug preparations -- *Name:* _____ ***License Number:*** _____

E. Are vaccines administered at this pharmacy? *(Yes/No)* _____

F. Does this pharmacy donate or dispense donated prescription drugs, devices, or supplies under 21 NCAC 46.2513? *(Yes/No)* _____

G. Will any component of this pharmacy's practice be Internet-based? *(Yes/No)* If yes, explain in detail below: _____

H. Does this pharmacy specialize in (or is this pharmacy certified in) certain pharmacy services? *(Yes/No)* _____

If "yes," please indicate *primary* type of specialty: ◯ Chemotherapy ◯ Diabetic Care ◯ Hemophilia ◯ IV Infusion

◯ Long Term Care ◯ Mail Order ◯ Nuclear ◯ Nutritional ◯ Remote Order Entry

◯ Non-sterile Compounding ◯ Sterile Compounding ◯ Weight Loss ◯ Other

I. Is the pharmacy accredited or certified by any organziation? *(Yes/No)* _____

Please list all organizations that have accredited or certified the Applicant Pharmacy's practices:

ITEM 8. Forms of operation and percent of ownership information:

Select one:

◯ Chain (11 or more stores) ◯ Independent ◯ Health Department ◯ Hospital (# Hospital Beds): _____

◯ "Free" Clinic ◯ Infusion ◯ Nursing Home ◯ Automated Dispensing System ◯ Other (Describe): _____

Incorporated or organized in the state of NC **on *(Date)*:** _____

Continued on next page

(ITEM 8. Forms of operation and percent of ownership information, continued):

Information below MUST be completed. Corporate chart or organizational structure may be attached.

NAMES OF OFFICERS AND OTHERS. INDICATE AMOUNT, WHERE APPROPRIATE, OF STOCK OWNED IF MORE THAN 10%. ALL HOSPITALS OR GOVERNMENT UNITS MUST COMPLETE THIS SECTION WITH EQUIVALENT OFFICIALS. NOTE APPLICABLE TITLES AND MAKE CHANGES WHERE NECESSARY.	BUSINESS ADDRESS	PERCENT OF OWNERSHIP	PHARMACIST LICENSE NUMBER
PRESIDENT, PRESIDING OFFICER OR EQUIVALENT			
VICE PRESIDENT OR EQUIVALENT			
SECRETARY OR EQUIVALENT			
TREASURER OR EQUIVALENT			
OTHERS			

Additional ownership information:

Do any of the following own any portion of, control, or have any beneficial interest in any other pharmacy (whether permitted in North Carolina or not), other than a publicly-traded corporation:

(a) the entity that is the proposed permit holder; *(Yes / No)* _____

(b) the entity with an ownership or other beneficial interest in the proposed permit holder; *(Yes / No)* _____

(c) any owner, officer or employee of the proposed permit holder (or any family member of any such person); *(Yes / No)* _____

(d) any owner, officer or employee of any entity with an ownership or other beneficial interest in the proposed permit holder (or any family member of any such person). *(Yes / No)* _____

If the answer to any of the above is yes, attach a list of each such pharmacy, list the person or entity with an ownership or other beneficial interest, describe the nature of that interest, and state whether the pharmacy has applied for, holds, or denied a North Carolina pharmacy permit.

ITEM 9. HAS THE APPLICANT PHARMACY EVER PREVIOUSLY APPLIED FOR A PHARMACY PERMIT IN NORTH CAROLINA?

(Yes / No) _____ If "yes," when? (month and year): _____

Under a different business name? *(Yes / No):* _____

If "yes," state the business name on the prior application: _____

Action on the application (denied, expired, incomplete): _____

ITEM 10. ARE YOU REGISTERED WITH THE NORTH CAROLINA SECRETARY OF STATE AS A BUSINESS? *(YES/NO)* _____

If "yes", provide a copy of the NC Secretary of State registration for the pharmacy.

If "no", select one of the following:

☐ I have a Registered Agent in NC and I am providing their contact information (attached to this application).

☐ I have read and I understand that per rule 21 NCAC 46.1607 (b) (8), the Secretary of State will be deemed my appointed agent by default. Sign and date here:

Signature _____ *Date* _____

ITEM 11. ADDITIONAL DOCUMENTS ARE REQUIRED. READ THE PROCEDURES SHEET THOROUGHLY AND COMPLETE THE CHECKLIST (FOUND HERE) BEFORE SUBMITTING APPLICATION.

COMPLETED Rx LABEL:

REQUIRED FOR ORIGINAL REGISTRATION ONLY
(ATTACH OR ENCLOSE LABEL)

ITEM 12. GPS COORDINATES: Please enter your pharmacy's GPS coordinates as degrees minutes-decimal, (e.g. 35°54.63, -78°58.998) or degree decimal format, (e.g. 35.9105, -78.9833)

Latitude (North): _____

Longitude (West): _____

Need help obtaining your pharmacy's GPS coordinates? Click here: *http://www.ncbop.org/gps.htm*

Continued on next page

CERTIFICATE A

(To be completed by a person listed in Item 8)

I do hereby certify that:

1) I have read this complete document and it is true and correct to the best of my knowledge and belief.

2) Any permit issued will be in the name of the pharmacist-manager signing Certificate B and is valid only if pharmacists remain on duty, as specified.

3) The pharmacist-manager has complete control over security in the pharmacy.

4) If there is a change in pharmacist-manager, the permit renewal will be returned to the Board within 5 days of the change.

5) If the pharmacist-manager position is vacated, the permit will be returned to the Board office to be held in trust and, if no replacement is made within 30 days, the Board may revoke the permit.

6) Adequate qualified staff will be present in the pharmacy.

7) No pharmaceutical services will be delivered or prescription drugs dispensed when a pharmacist is not on duty, except as specifically provided by statute or Board regulation.

8) I understand the laws governing the practice of pharmacy and distribution of drugs and assure their observance.

9) If the pharmacy is sold or discontinues business, the permit will be returned within 10 days to the Board office.

Name of Authorized Executive: _____

(Individual who is authorized to sign on behalf of the pharmacy)

_____

Signature and Title of Authorized Executive

_____

Date Filed

CERTIFICATE B

(To be executed by the pharmacist-manager of the pharmacy)

I do hereby certify that:

1) I have a current license to practice pharmacy in North Carolina or state of practice.

2) <u>I intend this position as pharmacist-manager is permanent and not temporary for the foreseeable future.</u> *Initial here:* _____

3) I am responsible for the conduct of this pharmacy according to the laws of this state, including, but not limited to, those specified in the Pharmacy Practice Act.

4) Any permit issued is valid only so long as I function as pharmacist-manager, and if I leave the position, the permit will be properly transferred to a successor or returned to the Board office.

5) No pharmacy services will be rendered or prescription drugs dispensed by a person not licensed as a pharmacist, except under the supervision of a person licensed as a pharmacist.

6) Should I be unable to fulfill the duties of pharmacist-manager, I will return the permit to the Board office within 5 days.

7) All licensees and registrants shall give the Board notice of a change of mailing address or a change of place of employment within 30 days after the change.

8) I understand that Pharmacist-Managers have many responsibilities in statutes and rules, including, but not limited to, the following:

a) Operating the pharmacy in accordance with all laws, Rule .1317 (28);
b) Proper pharmacy security, Rule .2502 (a);
c) Be present in the pharmacy at least one half the open hours, on the average, Rule .2502 (b);
d) Take a controlled substance inventory within 10 days of a Pharmacist-Manager or ownership change, Rule .2502 (c);
e) Develop and maintain a system to detect drug shortages, Rule.2502 (d);
f) Maintain control of all keys to the pharmacy or prescription department, Rule .2502 (e);
g) Have a plan to safeguard records and pharmaceuticals in case of a natural disaster such as a hurricane, Rule .2502 (j);
h) Remove outdated drugs from stock, Rule .2502 (k);
i) Report to the Board any deaths due to drugs dispensed through their pharmacy, Rule .2502 (l);
j) Comply with the Board's Rule on Patient Counseling, Rule .2504.

9) And that all technicians at this location are currently registered with this Board.

10) I have read this document and it is true and correct to the best of my knowledge and belief.

Name of Pharmacist-Manager: _____

Email address of Pharmacist-Manager: _____

Email address of PHARMACY: _____

Home Phone Number ***(no spaces or hyphens):*** _____

_____

Signature of Pharmacist-Manager

I understand that it is the Board's expectation that a pharmacy will begin pharmacy operations within six (6) months of the date that a permit is issued. I understand that if the pharmacy does not begin pharmacy operations within six (6) months, it is the pharmacist-manager's responsibility to contact the Board of Pharmacy with an explanation so that Board staff can determine whether the issued permit remains valid. *Initial here:* _____

The most recent inventory as required by state and federal controlled substances laws for this location has been compiled as of the close of business on _____ *(date)* and will remain on file in the pharmacy for the required period.

NORTH CAROLINA BOARD OF PHARMACY

In Re:	)	
_____	)	**PHARMACY SERVICES**
	)	**AFFIDAVIT**
Pharmacy Permit Application	)	
	)	

_____ ("Affiant"), being (a) the pharmacist applying for a North Carolina permit
[Pharmacist-Manager Name]
to operate a pharmacy on behalf of _____(the "Applicant Pharmacy"); and (b) either
[Name of Business]
the intended pharmacist-manager designated by Applicant Pharmacy, NCGS § 90-85.21 (for a pharmacy located within North Carolina), or the pharmacist designated by the Applicant Pharmacy as being "responsible for dispensing, shipping, mailing, or delivering dispensed legend drugs into [North Carolina]" and who "shall agree in writing . . . to be subject to the jurisdiction of the Board, the provisions of the [North Carolina Pharmacy Practice Act], and the rules adopted by the [North Carolina Board of Pharmacy]," NCGS § 90-85.21A(a) (for a pharmacy located outside of North Carolina); and having been duly sworn, states as follows:

1. Has the Applicant Pharmacy, any pharmacist affiliated with the Applicant Pharmacy, or any pharmacy technician affiliated with the Applicant Pharmacy <u>ever</u> been subject to any discipline by any licensing, permitting, or other regulatory authority, federal or state? "Subject to" includes any pending or unresolved action brought by any licensing, permitting or other regulatory authority, federal or state, against the Applicant Pharmacy. Discipline includes, <u>but is not limited to,</u> any letter of caution, letter of warning, reprimand, license suspension or revocation, permit suspension or revocation, or registration suspension or revocation. *No or Yes* _____
If the answer is "yes," please attach all relevant documents concerning this discipline, including the charging document, any order or letter issued by the disciplining body, and any decision issued by a court, administrative law judge, or other adjudicatory body (which documents shall be deemed incorporated by reference into the Affidavit).

2. Has the Applicant Pharmacy, any affiliate, or any assignee shipped or otherwise delivered <u>any</u> prescription drug product or <u>any</u> prescription medical device to any patient (human or animal) or practitioner (including veterinarians) in North Carolina? *(If this is an application for re-registration or transfer of ownership of a currently permitted pharmacy, answer N/A.)* *No, Yes, or N/A* _____
If the answer is "yes," please attach: (a) documentation of the product(s) shipped or otherwise delivered; and (b) the names, addresses, and phone numbers of any patient (human or animal) or practitioner (including veterinarians) to whom the product(s) were shipped or otherwise delivered. Such documents shall be deemed incorporated by reference into the Affidavit.

3. Does the Applicant Pharmacy dispense, distribute, or otherwise provide prescription drugs to any person or entity other than a person for whom the drug was prescribed? *No or Yes* _____

4. Has the Applicant Pharmacy, any affiliate, or any assignee shipped or otherwise delivered any compounded drug product for purposes of resale to any patient (human or animal), practitioner (including veterinarians), or any other entity in North Carolina? *No or Yes* _____
If the answer is "yes," please attach: (a) documentation of the compounded product shipped or otherwise delivered; and (b) the names,addresses, and phone numbers of any patient (human or veterinary), practitioner (including veterinarians), or other entity to whom the compounded products were shipped or otherwise delivered. Such documents shall be deemed incorporated by reference into the Affidavit.

5. Does the Applicant Pharmacy engage, or will the Applicant Pharmacy engage, in pharmacy compounding? *No or Yes* _____

6. If the answer to inquiry number 5 is "yes," does (or will) the Applicant Pharmacy market, or otherwise identify, itself as specializing in providing compounding services? *No or Yes* _____

7. If the answer to inquiry number 5 is "yes," does (or will) the pharmacy engage in:

(a) Non-sterile compounding. *No or Yes* _____

(b) Low-risk sterile compounding (as defined by USP <797>). *No or Yes* _____

(c) Medium-risk sterile compounding (as defined by USP <797>). *No or Yes* _____

(d) High-risk sterile compounding (as defined by USP <797>). *No or Yes* _____

Risk Level Guidance Document may be found here.

8. If the answer to inquiry number 5 is "yes," are the Applicant Pharmacy's compounding practices accredited by any organization?

No or Yes _____

Please list all organizations that have accredited the Applicant Pharmacy's compounding practices: _____

_____

9. Has the Applicant Pharmacy ever been denied accreditation of its compounding practices by any organization? *No or Yes* _____

If the answer is "yes," please explain in detail the circumstances and reasons why the Applicant Pharmacy did not receive accreditation.

10. Does the Applicant Pharmacy, any affiliate, or any assignee operate, or allow to be operated, in whole or in part -- either itself, on behalf of any third-party, or in conjunction with any third-party -- a website or websites? This includes <u>any</u> website affiliated with the Applicant Pharmacy, regardless of whether the Applicant Pharmacy is or is not an "Internet pharmacy." *No or Yes* _____

If the answer is "yes," please provide *(below)* the URL address of all such websites and describe the relationship between the Applicant Pharmacy and the entity operating the website(s). Any necessary additional sheets are incorporated into this affidavit by reference.

_____

_____

_____

_____

11. Does the Applicant Pharmacy, any affiliate, or any assignee use the Internet (including electronic mail) -- either itself, or through any business or other agreement with a third party -- to communicate with or obtain information from patients/consumers; and use such information, in whole or in part, to:

(a) solicit original prescriptions;
(b) allow patient-initiated refill requests;
(c) prescribe prescription drugs;
(d) provide consults to patients seeking to obtain prescription drugs; or
(e) refer patients to physicians, nurse practitioners, physician assistants, or any other health-care providers for consultation?

No or Yes _____ If the answer is "yes," please provide complete information about the program(s) and service(s) on separate sheets of paper, which shall be attached to, and incorporated by reference into, this affidavit.

12. Does the Applicant Pharmacy, any affiliate, or any assignee have any business or other relationship whereby it accepts, directly or by referral, prescriptions from any entity that arranges for on-line (Internet), telephone-only, or other remote consultations between patients/consumers and physicians, nurse practitioners, physician assistants, or any other health-care providers? *No or Yes* _____

If the answer is "yes," please provide complete information about the program(s) and service(s) on separate sheets of paper, which shall be attached to, and incorporated by reference into, this affidavit.

13. Does the Applicant Pharmacy, any affiliate, or any assignee provide, arrange, or otherwise facilitate -- either itself, or through any business or other agreement with a third party -- telephonic or other remote consultations between patients/consumers and physicians, nurse practitioners, physician assistants, or any other health-care providers, one purpose of the consultation being to prescribe prescription drugs? *No or Yes* _____ If the answer is "yes," please provide complete information about the program(s) and service(s) on separate sheets of paper, which shall be attached to, and incorporated by reference into, this affidavit.

14. Does the Applicant Pharmacy, any affiliate, or any assignee accept for filling or refilling any prescription issued to a patient/customer pursuant to an Internet-based questionnaire, an Internet-based consultation, a telephone-only or other remote consultation, or in any circumstances in which the prescriber has not conducted a physical examination of the patient and the prescriber and patient have no pre-existing patient-prescriber relationship that involved a physical examination? *No or Yes* _____ If the answer is "yes," please provide complete information about the circumstances under which the Applicant Pharmacy accepts such prescriptions for filling or refilling on separate sheets of paper, which shall be attached to, and incorporated by reference into, this affidavit.

15. Has the Applicant Pharmacy ever applied for accreditation as a Verified Internet Pharmacy Practice Site ("VIPPS") or Veterinary Verified Internet Pharmacy Practice Site ("V-VIPPS") by the National Association of Boards of Pharmacy ("NABP")?
No or Yes _____

16. If the answer to inquiry number 15 is "yes," is the Applicant Pharmacy VIPPS or V-VIPPS accredited by NABP? *No or Yes* _____

If the answer is "yes," refer to Rule 21 NCAC 46.1601 (d) (2) & (d) (3) and attach the required documentation.

If the answer is "no," please explain in detail the circumstances and reasons why the Applicant Pharmacy did not receive VIPPS or V-VIPPS accreditation.

17. The Affiant understands that, under North Carolina law, NCGS § 90-85.38, the North Carolina Board of Pharmacy ("Board") may "suspend, revoke, or refuse to grant or renew any permit" if any person has "[m]ade false representations or withheld material information in connection with securing a license or permit."

18. The Affiant understands that, under North Carolina law, NCGS § 90-85.38, "[a]ny license or permit obtained through false representation or withholding of material information shall be void and of no effect."

19. The Affiant understands that the information sought in this Affidavit by the Board is material to the Board's determination of whether to issue a permit to the Applicant Pharmacy.

20. The Affiant understands that any false representation or withholding of information sought in this Affidavit shall result in the Board's taking action against any permit granted to the Applicant Pharmacy including revocation and voiding of such permit.

21. The Affiant understands that supplying the information sought in this Affidavit does not result in any guarantee or promise, express or implied, that the Board will grant Applicant Pharmacy a permit.

This the _____ day of _____ , 20 _____ .

_____
Pharmacist-Manager Signature

State of _____

County/Parish of _____

Sworn to and subscribed before me this _____ day of _____, 20____.

_____
Notary Public

My Commission Expires: _____

North Carolina Board of Pharmacy

Print Form

6015 Farrington Road, Suite 201
Chapel Hill, North Carolina 27517
Phone: (919) 246-1050
Fax: (919) 246-1056
www.ncbop.org

AUTHORIZATION FOR CREDIT CARD CHARGE

THE NC BOARD OF PHARMACY ONLY ACCEPTS PAYMENT VIA VISA, MASTERCARD, DISCOVER, OR AMERICAN EXPRESS.
WE DO NOT ACCEPT CHECKS.

FEE FOR NEW PHARMACY PERMIT, TRANSFER OF OWNERSHIP, OR RE-REGISTRATION IS $500.00.
YOUR CREDIT CARD WILL BE CHARGED WHEN THIS FORM IS RECEIVED IN THE BOARD OFFICE.
ALL FEES ARE NON-REFUNDABLE.

☐ VISA ☐ MasterCard ☐ DISCOVER

CREDIT CARD NUMBER *(VISA, MC, or DISCOVER)*: _____ _____ _____ _____

☐ AMERICAN EXPRESS

CREDIT CARD NUMBER *(AMERICAN EXPRESS)*: _____ _____ _____

EXPIRATION DATE *(mm / yyyy)*: _____ / _____

NAME *(exactly as it appears on the credit card)*: _____

BILLING ADDRESS: _____

ADDRESS LINE 2: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE NUMBER *(will only be used in case of card processing problems)*: _____

EMAIL ADDRESS: _____

SIGNATURE: _____

THIS FORM WILL BE DESTROYED IMMEDIATELY FOLLOWING PROCESSING OF PAYMENT.

Revised Nov 2016