EEG & Clinical Neuroscience Society

FAX-VOICE MAIL: 888-531-5335

I HEREBY AUTHORIZE PSI TO CHARGE MY CREDIT CARD:

AMEX_____**exp. Date** _____

VISA_____**exp Date**_____

MASTERCARD_____**exp. Date**_____

IN THE AMOUNT OF:

FOR (specify purpose):
DATE:

I AGREE TO PAY ABOVE TOTAL AMOUNT ACCORDING TO CARD ISSUER AGREEMENT.

PRINT NAME(with initial) (if applicable):_____

SIGNATURE OF CARD HOLDER:_____

(HOME) ZIP CODE: