

## Credit Card Authorization Form

### For Faxed Applications

Please print, complete and fax this form along with your completed application to:

Fax: (847) 427-1294

### For Mailed Applications

Please print, complete and mail this form along with your completed application.

American College of Allergy, Asthma & Immunology  
85 West Algonquin Road,  
Suite 550 Arlington Heights, IL 60005

Fax: (847) 427-1294  
Phone: (847) 427-1200

Name of Applicant: \_\_\_\_\_  
(please print)

Please charge my credit card for the following Membership Application fee:

- Fellows - \$50
- Members - \$25
- Members promoted to fellows - \$25
- Scientific fellows - \$25

### Credit Card Information

Type of Credit Card:  Master Card  Visa Card  American Express

Credit Card Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Credit Card Verification #: \_\_\_\_\_ (3-4 digit security number)

Credit Card Expiration: \_\_\_\_\_ (Date).

Name On Credit Card: \_\_\_\_\_

CC Billing Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Signature: \_\_\_\_\_

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

**Please print this Form then fill in the information and fax to:**

American College of Allergy, Asthma & Immunology-  
Fax: (847) 427-1294

**Your application cannot be processed until this form is received.**