Customer #_____

Experts in Blood Pressure Management™

PharmaSmart®

PharmaSmart Canada Corp.

Credit Card Payment Information

Store Name: _____

Name on Credit Card: _____

Credit Card Billing Address: _____

_____

Telephone Number: _____

Fax Number: _____

Contact Person: _____

Email Address: _____

Credit Card Information

Credit Card Account Number: _____

Credit Card Type (Circle One): Visa Mastercard American Express

Card Verification Digits: _____

Expiration Date: _____

Payment Type (Circle One): Recurring Payment One-Time Payment

I hereby authorize Pharma-Smart Canada Corp. to process payment using my credit card account named above. I am aware that my account will be debited with the first 7-10 business days of each month.

_____

Name of Authorized Person and Title (Please Print)

_____

Authorized Signature

_____

Date

Please forward completed form by fax to (585) 427-8165 or by e-mail to accountsreceivable@pharmasmart.com.