Customer #______________

Experts in Blood Pressure Management™

PharmaSmart®

PharmaSmart International Inc.

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 Discover

Card Verification Digits: _________________________

Expiration Date: _________________________

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

I hereby authorize Pharma-Smart International Inc. 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.