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DEDICATED TO RESTORING
SIGHT AROUND THE WORLD®

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(1-800-393-2265)

International Cornea Project Credit Card Authorization Form

The following information must be filled out completely and signed for this transaction to be valid.

Cardholder Information: (Please print)

Card Type: MasterCard Visa American Express

Card#: _____

Expiration Date: _____

Name: _____

Address: _____

City, State, Zip: _____

Payment to be applied as follows:

INVOICE #	\$ AMOUNT
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INVOICE #	\$ AMOUNT
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I agree to pay the above total amount according to the merchant agreement.

Signature

Date