

**All Saints Catholic School
641 5th Avenue
Lewiston, ID 83501
(208) 743-4411
Fax (208) 743-9563**

**Credit Card Charge
Authorization Form**

Name _____

Address _____

City _____ State _____ Zip _____

**I authorize All Saints Catholic School (ASCS) to charge my
credit card monthly as per the instructions listed below:**

**Visa, Mastercard or Discover Accepted
(Please be aware that the school is charged 2% to 3% to process
each credit card transaction.)**

Name as it appears on the card

Visa/Mastercard/Discover Number _____

Expiration Date _____

Amount per Month \$ _____

***Start Date** _____

***End Date** _____

Signature _____ **Date** _____

***All credit card charges will be processed on the 15th of each month.**

Please return completed form to ASCS - Attention: Bookkeeper

(OVER)