

Maine Dental Association

*Please Print Clearly*

Your Name: \_\_\_\_\_ Business Name: \_\_\_\_\_

Name on Card: \_\_\_\_\_ Phone: \_\_\_\_\_

Billing Address on Card: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Email: \_\_\_\_\_



Card #:

Security Code: \_\_\_\_\_ (3 digits on back of card)

Exp. Date: \_\_\_\_\_  
Month Year

Amount \$ \_\_\_\_\_ Cardholder Signature: \_\_\_\_\_

Disclaimer: A \$50.00 fee will be added to payment if provided information does not match credit card information on file with credit card company and has to be resubmitted to credit card company. By signing above you agree to these terms and conditions.

- |              |                    |                         |             |
|--------------|--------------------|-------------------------|-------------|
| Advocacy     | Annual Convention  | Charitable Foundation   | Dues        |
| Exhibitor    | Individual CE      | NewsJournal Advertising | PAC         |
| Package Plan | Roster Advertising | Sponsorship             | Other _____ |
| CNA          |                    |                         |             |

Please make sure to print legibly and note Disclaimer: A \$50 fee will be added to your payment if provided information does not match credit card information on file with credit card company or written information is unreadable - and has to be resubmitted to credit card company. By signing above you agree to these terms and conditions.