

## 2024 Membership Dues Installment Payment Authorization Form

### MEMBER INFORMATION

First Name	Middle Initial	Last Name
Phone		
Email (required for communication purposes)		

### MEMBER'S AUTHORIZATION

By signing this form, I authorize the American College of Prosthodontists to charge my credit card for three installment payments for my ACP membership dues on the dates below. I understand that the charges will be automatically processed on the dates listed below:

<p style="text-align: center;"><u>Three Installments</u> Payments Processed On:</p> <ul style="list-style-type: none"><li>• March 29</li><li>• April 30</li><li>• May 31</li></ul>
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Member Signature	Date
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### MEMBER INFORMATION

MasterCard     Visa     American Express

Cardholder Name	
Credit Card Number	Exp. Date

Signature

Mail or fax your installment authorization form to:

American College of Prosthodontists  
5198 Eagle Way  
Chicago, IL 60678-5198  
Phone: (312) 573-1260  
Fax: (312) 573-1257