

HEMA TRANSPORTATION

CREDIT CARD AUTHORIZATION FORM

Date _____

I _____ Authorize _____ to charge my credit card
(NAME) (COMPANY)

For services rendered. Not to exceed the amount shown.

REFERENCE _____

AMOUNT \$ _____ USD.

CREDIT CARD TYPE _____

CREDIT CARD # _____

CARD CVV # _____

EXPIRATION DATE _____

BILLING ADDRESS _____

BILLING ZIP CODE _____

NAME ON CARD _____
(As it appears on card)

SIGNATURE

DATE

FAX OR E-MAIL TO:

Hema Transportation Services, Inc.

Hema@hemalimo.com

Devita@hemalimo.com

(407) 354.0999/ (407)859-1414

(407) 641-5111

CANCLATION POLICY: PLEASE HAVE THE CLIENT INICIAL.

1) IF THE CLIENT CANCELLES 5 DAY BEFORE PICKUP DATES THERE WILL BE CHARGE 50% OF TOTAL COST OF THE RESERVATION. _____

2) IF THE CLIENT CANCELLES WITHIN 24 HOUR ON THE PICKUP TIME OF THE RESERVATION THERE WILL BE NO REFUND. _____

3) ALL LAST MINUTE RESERVATION IS SUBJECT TO NO REFUND. _____

NOTES:

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ATTACH RECEIPT HERE