**Credit Card Payment Authorization Form**

Please fill in this form in English and sign. Return it via Fax: (852) 2145 7237 or Email (the scanned copy): wfnrgadcd2014@cuhk.edu.hk.

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| **Personal Information** | | | |
| Title | Professor  Doctor  Mr.  Ms.  Mrs. | | |
| Gender | Male  Female | | |
| Surname/ Last Name |  | | |
| First Name |  | | |
| Email |  | | |
|  |  | | |
| **Payment Information** | | | |
| Card Type | Visa  Master | | |
| Cardholder Name |  | | |
| Card Number |  | | |
| Expiry Date *(mm/yyyy)* |  | / |  |
| Amount ***(HKD only)*** | HKD | | |
| Signature |  | | |

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| **No refund will be made once the payment is confirmed** |