



CALIFORNIA EMERGENCY MEDICAL SERVICES AUTHORITY
PARAMEDIC LICENSURE PROGRAM
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 TELEPHONE (916) 323-9875 / FAX (916) 324-2875
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STATE USE ONLY

Receipt Number:

CREDIT CARD AUTHORIZATION FORM

Applicant Name: _____ **P-Number** _____
 (If applicable)

Card Type:

Visa

Mastercard

Debit

Name: _____
 (As name appears on card)

Credit Card Number: _____
 *Only Visa and Mastercard credit cards are accepted

Expiration Date (MM/YY): _____

CVC2 Code (Security Code): _____ **Billing Zip Code:** _____

Payment Amount: _____

Signature of Cardholder: _____

To receive a receipt of payment, please provide your email address:

**Do not add application information to this form.
 It will be shredded.**