

Mission:

To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.



Rick Scott
Governor

Celeste Philip, MD, MPH
State Surgeon General and Secretary

Vision: To be the Healthiest State in the Nation

Facility: (Name) _____ Project Name: _____

Address: _____ Purpose: Permit [] Certification Clearance [] Other []

City, State, Zip: _____ Phone: _____

TO BROWARD COUNTY HEALTH DEPARTMENT CREDIT CARD AUTHORIZATION

We have taken an extra step to protect our clients from credit card fraud. An authorization form, filled out and faxed to us along with a copy of your current ID will ensure us that the person using your card is you. This is to confirm that you are using our services with your credit card. It is very important for us to have you complete this form and fax it back to us as soon as possible, so we can process your payment. Thank you for your cooperation.

Cardholder: _____ Card #: _____

Circle Type: **VISA MASTERCARD AMERICAN EXPRESS DISCOVER**

Expiration Date: _____ Security Code: _____

Credit Card Billing Address: _____

City, State, Zip: _____

Telephone Number: _____

I AUTHORIZE BROWARD COUNTY HEALTH DEPARTMENT TO CHARGE MY ACCOUNT FOR THE FOLLOWING:

Amount: \$ _____ and Service _____

If this is a renewal of BCHD License or Permit, Please print your Permit # _____

Signature: _____ **Date:** _____

FAX THIS FORM TO: (954) 467-4898

Please make any updates to the renewal of your Broward County Health Department License or Permit.

Facility Name: _____ **License/Permit #:** _____

Location Address: _____ **Location:** City, State, Zip _____

Location Phone: _____ **Location Fax:** _____

Business Name: _____ **Address:** _____

City, State, Zip: _____ **Owner/Manager/Contact** _____

Phone: _____ **Email:** _____ **Fax #:** _____

PLEASE PRINT CLEARLY OR TYPE ALL INFORMATION