

Mission:

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



Ron DeSantis
Governor

Scott A. Rivkees, MD
State Surgeon General

Vision: To be the **Healthiest State** in the Nation

None of the data entered on this form will be saved to the St. Johns County Health Department website or database

PLEASE PRINT CLEARLY OR USE YOU COMPUTER TO ENTER ALL APPLICABLE INFORMATION

TO: St. Johns County Health Department

CREDIT CARD AUTHORIZATION

Type of Certificate: BIRTH DEATH

Name: FIRST _____ MI _____ LAST _____

Address: _____

City: _____ State: _____ Zip Code: _____

Card Holder: _____ Credit Card# _____
Enter name as it appears on card

Check Type: VISA Master Card

Expiration Date: _____ (mm/yyyy) Three Digit Security Code: _____

Credit Card Billing Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Email Address: _____

I authorize St. Johns County Health Department to charge my credit card account for the following:

Amount \$: _____

Signature: _____ Date: _____

**Be sure to sign this form then MAIL completed form, application and current State issued License or ID to:
Florida Department of Health in St. Johns County
200 San Sebastian View Suite 1322
St. Augustine, FL 32084**