

**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**  
Surgeon General and Secretary

**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 YOUR COMPUTER TO ENTER ALL APPLICABLE INFORMATION**

TO: St. Johns County Health Department

**CREDIT CARD AUTHORIZATION**

We have taken an extra step to protect our clients from credit card fraud by requiring you to fill out this application form. Fax This authorization form, appropriate application (birth or death) and photocopy of your valid State Driver's License or State ID to **904-823-4062**. Please enlarge and lighten your identification before faxing so that we will be able to read you're ID. This will ensure us that you are the person using the credit card for our services. Thank you for your cooperation.

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 and then FAX the completed form, application and current State issued License or ID to 904-823-4062**