

**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

**Environmental Health Credit/Debit Card Authorization Form**

**Card Holder Information**

_____ Company Name <b>(required)</b>	_____ Authorization Date <b>(required)</b>
_____ Card Holder's Name <b>(required)</b>	_____ Card Holder's Title
_____ Billing Address (No P.O. Boxes)	_____ City, State, Zip Code <b>(required)</b>
_____ Card Holder's Phone Number	_____ Card Holder's Email Address

**Transaction Information**

_____ Service Type (i.e., Septic, Well, Food, Pool, etc.) <b>(required)</b>	_____ Amount Authorized <b>(required)</b>
_____ Service Address or Permit Number <b>(required)</b>	

**Attestation:**

I, the undersigned, hereby authorize the Florida Department of Health in St. Johns County to charge the amount listed above to my credit card as payment for the above referenced services. I understand that my credit card will be charged upon receipt of this form and that my signature authorizes this charge. I further acknowledge that this authorization is valid only for the amount expressly listed above, that no additional charges will be made, and that this authorization expires one (1) business day from the date listed above.

_____ Card Holder Signature <b>(required)</b>	_____ Date <b>(required)</b>
--	---------------------------------

**Credit Card Information (VISA or MasterCard Only)**

_____ Credit Card Number <b>(required)</b>	_____ Expiration Date <b>(required)</b>	_____ Security Code <b>(required)</b>
---	--	--

Upon completion, please fax to (904) 428-5659