

Attendee Name

Practice Name: _____

Provider Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Office Phone: _____ Fax: _____

Mobile: _____ Email: _____

Your Order Information

Item:	Description:	Price:	Quantity:	Total:
[] MW	Marketing Workshop (Staff must be with Doctor/Clinic Owner)	\$99.00	—	

Excite Medical Headquarters

Location: 4710 Eisenhower Blvd, Suite A-12
 Tampa, FL 33634

Subtotal: _____

_____ Doctor/ Clinic Owner Acknowledges that staff will be accompanied by them.
 Initials

Card Number: _____ Exp: ____ / ____

Card Type: VISA American Express MasterCard

Authorized Amount: \$ _____ CVC Code: _____

I, _____ authorize EXCITE MEDICAL to charge the above referenced credit card for this order. I understand that subject to the conditions of cancellation by EXCITE MEDICAL, that otherwise all sales are final

Print Name Card Holder Signature Date