Windsor University School of Medicine

P.O. Box 1621, Brighton's
Estate, Cayon
St. Kitts
Tel: 1-869-466-1220 / 6157
Fax: 1-869-465-0593
email:
accounts@windsor.edu

CREDIT CARD VERIFICATION FORM

Please check one of the following payment choices.
Please scan and email the form to creditcard@windsor.edu

Mastercard _____
(3.5% credit processing charge)

Visa_____
(3.5% credit processing charge)

Credit card number: _____

Expiration date (MM/YY)_____

C V V :_____

Name that appears on the credit card: _____

Billing address of Cardholder: _____

_____

_____

Contact Phone Number: _____

Student's Full Name: _____

Amount to be charged (3.5% will be added on top of this amount): _____

Reason for transaction: _____

PLEASE READ THE FOLLOWING

I, the above-mentioned cardholder/student, hereby agree to all additional finance charges that apply to the processing of payments on my credit card. I accept these charges in addition to the amount that is to be charged on my credit card. I understand these charges and confirm the above information is accurate. I authorize the permission to the payee to deduct the above-mentioned dollar amount.
Please submit - Government Issued ID, Copy of Credit Card (both sides) with this form

Signature: _____ Date: _____ (mm/dd/yyyy)