

Credit/Debit Card Payment Form

Customer Name:		
Billing Address:		
City:	Postcode/Zip code:	Country:
Email:		Phone:
Shipping Address (if different from above)		
City:	Postcode/Zip code:	Country:

Order details		
Quote Number Ref:	Quantity	Amt £ exc. VAT
VenturiOne Products		
Single license-Unlimited		
Single license- 1 year		
Network license- 3 users		
Network license- 5 users		
Network license- __custom (enter no. of users)		
	Net Amount	
	VAT	
	Shipping Rate	
	Total	

Credit/Debit Card Details:

Maestro
 MasterCard
 Solo
 Visa
 Visa Electron

Name on Card _____

Card Number _____

Expiry Date (mm/yyyy) _____

CSC Number _____ (Typically the last 3 digits on the back of the card)

Please phone, fax or email this form to:

Applied Cytometry
 Matrix Business Centre
 Nobel Way
 Dinnington, Sheffield
 S25 3QB

T: +44(0) 1909 547 210
 F: +44(0) 1909 547 209
 E: sales@appliedcytometry.com

IMPORTANT: Payment card details will not be stored for future use.