



EyeHub 877-870-9386

Fax back to: 541-247-0938

WEBSITE (domain name) AUTHORIZATION

Doctor's Name: _____

Company Name: _____

Billing address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Domain name requested: **WWW.**

Billing email to let you know we've charged your credit card: _____

Domain names are registered to the Doctor as the owner. EyeHub.com is only technical contact and notifies doctor when it's time to renew.

Please circle number of years you would like this domain name registered

1 year \$35.00 5 years \$100.00

2 years \$50.00 10 years \$175.00

3 years \$75.00

Signature of primary doctor: _____ Date _____

Credit Card Billing Information



Card Type (Circle One): _____

Name on Card: _____

Card Number: _____ Exp. Date: _____

CVC: _____ (3 digit code on back) or (4 digit code on front of American Express)

Billing Street Address for card: _____

City: _____ State: _____ ZIP: _____

I authorize EyeHub to bill my credit card for domain name.

Cardholder's Signature: _____ Date _____