

Credit Card Payment

Name of Event: **Olympic SuperStars 5 week Fall Clinic 2017**

Player Name \_\_\_\_\_

Circle: Visa MC Discover

Credit Card Number: \_\_\_\_\_

EXP Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ 3 Digit Security Code: \_\_\_\_\_

Name on the Card \_\_\_\_\_

Total Amount **\$45 + \$5** Credit Card Fee: \$\_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Billing Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Contact Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Mail to:  
Olympic Soccer Academy  
24513 Norwood Drive  
Plainfield, IL 60585  
Or Fax this to: **815.439.9171**

