

Credit Card Payment

Name of Event: **Super 6 Spring 5 week clinic**

Children Names _____

Circle: Visa MC Discover

Credit Card Number: _____

EXP Date: ____/____/____ 3 Digit Security Code: _____

Name on the Card _____

\$109 per player

Total Amount + \$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**

