AMERICAN BOARD OF
FORENSIC ACCOUNTING

This authorization form confirms the ABFA's agreement with ______________, in which you acknowledge indebtedness to the ABFA as specified below and promise to pay the amount due in monthly installments as follows.

Payment Period ___/__/__ through __/__/__

Total Amount Due: $___________

Payment Schedule ________equal monthly installments of

$__________ with the first payment due

__/__/__ and final payment of $______. __ due __/__/__

The plan is contingent upon receipt of the signed payment plan agreement and good faith payment of $____. __ due by _______________,20__. This payment will be applied to the total amount due listed above.

All other payments are due on the ____ (_) day of each month. Payments shall be deemed delinquent if automatic payment is declined and payment not received in our office within 30 days. In the case of default, your status with the ABFA will be inactive until your balance is paid in full.

Person Authorized: First Name___________________ Last Name_______________

Email Address: ____

Phone Number: ____

Credit Card information:

Credit Card Number: ____

Expiration Date: ______________________ Security Code: ____________________

I authorize the ABFA to keep my signature on file and to charge my payments to the credit card selected above. This agreement will remain valid until the balance is paid in full or a request is made in writing to cancel the payments and a new credit card is provided along with a new authorization form.

Authorized Signature_______________________ Date________________