Nevada Dental
ASSOCIATION

Classified Ads Payment Form

Date:_____

Name: *for ad submission*_____

Phone #_____Email Address (for receipt) _____

Ad Title_____

Name on CC_____

Billing Address_____

City_____State_____Zip code_____

CC #_____

Exp Date_____CVV_____

Amount Total___(to verify)_____

Expiration date on Ad_____(2 months from posting date)_____

Authorized Signature_____

This form can be faxed to: 702-255-3302 or email to Suzzi.fobbs@nvda.org.