

Aris Pharmaceuticals Inc.

CREDIT CARD AUTHORIZATION

CREDIT CARD HOLDER INFORMATION					
NAME ON CREDIT CARD					
TYPE OF CREDIT CARD	VISA	MC	AMEX	DISCOVER	OTHER
TYPE OF ACCOUNT	PERSONAL		BUSINESS		
COMPANY NAME					

ACCOUNT NUMBER					
EXPIRATION DATE			CVV CODE ON THE BACK		
BILLING ADDRESS					
CITY		STATE		ZIP CODE	
PHONE		EMAIL		FAX NUMBER	

AUTHORIZED USER OF CREDIT CARD	SAME AS CREDIT CARD HOLDER (YES)	IF NO, PLEASE ALSO FILL:	
NAME			
COMPANY			
PHONE NUMBER			
EMAIL ADDRESS			
IDENTIFICATION			
RELATION TO HOLDER			
TYPE OF CHARGES	GOODS	SERVICE	OTHER
AUTHORIZED AMOUNT			
DATES OF CHARGES			

AUTHORIZATION OF CARD USE			
<p>I certify that I am the authorized holder OR signer of the credit card referenced above.</p> <p>I certify that all information above is complete and accurate.</p> <p>I hereby authorize collection of payment for all charges as indicated above. Charges may not exceed the amount listed above in the "AUTHORIZED AMOUNT" field. I understand this is only for up to this amount during the time period of "DATES OF CHARGES" referenced above.</p>			
CARDHOLDER NAME			
SIGNATURE			DATE

Aris Pharmaceuticals Inc. www.arispharma.com 2000 Hartel St, Suite B, Levittown, PA 19057
 Phone: (800) 230-3521

Please fax this Signed form to: 1-267-395-2279 or email to: sales@arispharma.com