PERSONAL CREDIT RELEASE FORM

Please return form via fax to 971-285-4336 or scan and email to businessoffice@achs.edu.

Your Full Legal Name: _____
Full Address: _____
_____
Social Security Number: _____-____-_____
Date of Birth: _____
Telephone Number: (_____) _____-_____
Email address: _____

I, _____ authorize American College of Healthcare Sciences or its agency to investigate my personal credit and financial records. As part of such investigation, I authorize American College of Healthcare Sciences to request and obtain consumer credit reports on me in connection with the opening, monitoring, renewal and extension of this and other accounts with American College of Healthcare Sciences and the marketing of other products and services to me and my business by American College of Healthcare Sciences. If I request, you will tell me whether my consumer credit report was requested and if so the name and address of the consumer credit agency that furnished the report.

_____ _____
(Signature) (Date)

Payment Information:
The current credit check fee is $7.50. You may include your payment information below or call the Business Office at 800-487-8839.

Card Type (Circle One): Visa/MC/Amex/Discover/JCB
Name as it appears on Credit Card: _____
Credit Card#: _____
Exp: _____ CVV2#_____
(CVV2# = 3-digit code on signature line on back of credit card, or 4=digit code on the front of the American express card)

For College Use Only:

Date Received: _____	Date Processed: _____	SS# Match? ☐ Yes ☐ No
Need FSC Review? ☐ Yes ☐ No	PIP Approved? ☐ Yes ☐ No	Initials: _____ Date: _____