The Berkley Doll Hospital

Customer Information Form
(Please Print)

Name:_____
Address: _____

City:_____ State_____ Zip _____

Daytime Tel: _____ Fax: _____

E-mail: _____
(Please write e-mail address very legibly—it must be exact)

Number of dolls to be evaluated_____ x $25* = _____

Number of Boxes being sent to the Berkley Doll Hospital _____

Circle Payment Type: VISA / MasterCard

CC #: _____-_____-_____-_____ CVV#: _____

Exp. Date _____

Exact Billing Name and Address of cardholder (if different from that shown above):

Name: _____

Address: _____

City: _____ State:_____ Zip:_____

Signature of Cardholder:_____Date: _____

* Please note that the $25 fee covers minimum return shipping of $10. We will notify you of any additional shipping charge (based on size and shipping destination) before your doll(s) are returned.