Photography/Videography Permit

Please Check Only One: ☐ Daily $50.00
☐ Annual $250.00

Date: _____

Business Name: _____

Photographer Name: _____

Mailing Address: _____

City: _____ **State:** _____ **Zip Code:**_____

Phone: *(circle)* home / cell / work (_____) _____

Email: _____

Signature:_____

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*IF this is a **GIFT MEMBERSHIP**, who is **PURCHASING** the Gift Membership?*

LAST: _____**FIRST:**_____

Title: *(circle)* Mrs. / Mr. / Ms. / Miss / Other: _____

Mailing Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone: (_____) _____ **Email:** _____

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PAYMENT TOTAL $_____ Payable to *'Wellfield Botanic Gardens'* by Check #_____ / Cash / Credit Card
Credit Card type *(circle)* VISA / MC / DISC / AMEX Name on Card: _____

Card # _____ Exp: _____ CCV: _____Billing Zip code if different from above: _____

Other Payment Type: _____ Comments: _____

Front Office: Staff Initials _____ Pmt Received Y / N Altru _____ Temp Card(s) Issued _____ Order # ____ _____

Back Office: Data Entry Y / N Card(s) Mailed Y / N Complete Y / N Notes: _____