GIFT CERTIFICATE REQUEST FORM

Amount: ____

To: ____

From: ____

Address to send: ____

____

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Billing Information:
Credit Card: Visa; Master Card; Amex

#______________________________________ Exp.____________

Name (as it appears on the credit card): ______________________________

Billing Address: ____

____

____

Phone: ____________________ Fax: ______________________

E Mail: ____

Comments or Special Requests: ______________________________

____

Signature: ____

Please fax to: 707-433-6633 (We will Confirm Receipt)

PLEASE MAIL THIS FORM TO:
421 NORTH STREET HEALDSBURG, CALIFORNIA 95448 PHONE 707 433 3311 FAX 707 433 6633
CYRUSRESTAURANT.COM