



Credit Card Authorization Form - REGISTRATION



DATE (mm/dd/yyyy): _____

CLIENT NAME (Please print): _____

CONTACT INFORMATION (Delivery address, if applicable)			
Street, PO BOX, APT#			
City/Town	Province/State	Postal Code/Zip Code	Country
Email			

SERVICE/PRODUCT (Check all that apply):		
<input type="checkbox"/> Corporation Certificate and/or Permit Application	<input type="checkbox"/> Licensure	<input type="checkbox"/> Summative Assessment
<input type="checkbox"/> CPC Certificate	<input type="checkbox"/> Physician Mailing Labels	<input type="checkbox"/> Summative Assessment Administration Fee
	<input type="checkbox"/> Physician Mailing List	<input type="checkbox"/> Supervision
	<input type="checkbox"/> Replacement Document	<input type="checkbox"/> Other _____

PAYMENT INFORMATION AND AUTHORIZATION

I, _____
(Cardholder's Name – Please Print)

authorize the College of Physicians and Surgeons of Saskatchewan to charge my credit card for the amount stated below.

Amount Authorized: \$ _____

Cardholder Signature: _____
Please print and sign manually. Electronic signatures not accepted.

Name as it appears on card: _____

Credit Card Number:

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Expiration Date:

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 Visa/Visa Debit MasterCard/Mastercard Debit

FAX OR MAIL THIS FORM TO: Fax: (306) 912-7437
College of Physicians and Surgeons of Saskatchewan
101-2174 Airport Drive, Saskatoon, SK S7L 6M6