Credit Card Authorization Form

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):*

- ☐ Corporation Certificate and/or Permit Application
- ☐ CPC Certificate
- ☐ Discipline
- ☐ Lab Inspection
- ☐ Licensure
- ☐ Physician Mailing Labels
- ☐ Physician Mailing List
- ☐ Replacement Document
- ☐ Summative Assessment
- ☐ Summative Assessment Administration Fee
- ☐ Supervision
- ☐ 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: |__|__|__|__| |__|__|__|__| |__|__|__|__| |__|__|__|__|

Expiration Date: |__|__| |__|__| ☐ Visa/Visa Debit ☐ MasterCard/Mastercard Debit

FAX OR MAIL THIS FORM TO:

Fax: (306) 244-0090

College of Physicians and Surgeons of Saskatchewan
101-2174 Airport Drive, Saskatoon, SK S7L 6M6