College of Physicians and Surgeons
500, 321A 21st Street East, SASKATOON SK S7K 0C1
Phone: (306) 244-7355 Fax: (306) 244-0090

Credit Card Charge Form

Date: ____________________

Physician Name (Please Print): ____

I, _____________________________________ authorize the College of Physicians and
(Please Print Name)
Surgeons of Saskatchewan to charge my credit card for the amount stated below.

Cardholder Name: ____

Address Receipt to be sent to: _____________________________ Postal Code: ________

Cardholder Signature: __________________________________

Amount Authorized: $ __________________________

FOR STAFF USE ONLY

Date Received: _____________ Date Processed: __________________________

Amount Charged: ___________ Credit Card Type: _ Visa _ Mastercard

Credit Card # Disposed (date): Staff Initials:

Please check one:

☐ Visa ☐ Mastercard

Credit Card Number |_|_|_|_| |_|_|_|_| |_|_|_|_| |_|_|_|_|

Expiration Date |_|_| |_|_|