

THE COLLEGE OF PHYSICIANS AND SURGEONS OF  
NEWFOUNDLAND AND LABRADOR

PAYMENT FORM

Physician name: \_\_\_\_\_

Name on Credit Card: \_\_\_\_\_

Licence No. (if applicable) \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Telephone No. \_\_\_\_\_

Email address \_\_\_\_\_

Date \_\_\_\_\_

Please indicate method of payment:

Visa Card No. \_\_\_\_\_

Expiry date: \_\_\_\_\_/\_\_\_\_\_  
Month Year

CVV/CSC No: \_\_\_\_\_  
(3 digit security code on back of card)

MasterCard No. \_\_\_\_\_

Expiry date: \_\_\_\_\_/\_\_\_\_\_  
Month Year

CVV/CSC No: \_\_\_\_\_  
(3 digit security code on back of card)

Amount: \$ \_\_\_\_\_

Payment is only authorized for the following item(s):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature