CPSS College of Physicians and Surgeons of Saskatchewan

REGISTRATION SERVICES

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
Phone/Cell		Email	

SERVICE/PRODUCT *(Check all that apply):*

- ☐ Corporation Certificate and/or Permit Application
- ☐ CPC Certificate
- ☐ 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

To protect your information, we cannot accept authorization forms by email.

FAX OR MAIL THIS FORM TO:

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