



1000-1661 PORTAGE AVENUE WINNIPEG, MANITOBA R3J 3T7
TEL: (204) 774-4344 FAX: (204) 774-0750
E-MAIL: registration@cpsm.mb.ca

AUTHORIZATION FOR PAYMENT
Clinical Assistant

Visa ___ MasterCard ___ American Express ___

Amount Authorized: ___ **\$330 Documentation Fee**

Applicants Name _____

Name on card (please print) _____

Credit card number _____ / _____ / _____ / _____

Expiry date _____ / _____ (mm/yy) **CVV** _____

Credit Card Authorization signature _____

**PLEASE E-MAIL, FAX (204-774-0750), PHONE (204-774-4344)
OR MAIL YOUR INFORMATION TO OUR OFFICE.**