AUTHORIZATION FOR PAYMENT

MEDICAL CORPORATION FEES

Visa _____ **MasterCard** _____ **American Express** _____

Amount Authorized _____

_____ **$350.00 Registration fee**

_____ **$150.00 Annual license fee**

_____ **$50.00 Late fee**

Name of member (please print) _____

Name on credit card (please print) _____

Credit card number _____/_____/_____/_____ Expiry date ___/___ (mm/yy)

Credit Card Authorization signature _____

NOTE: The College of Physicians and Surgeons of Manitoba cannot accept credit card information via email. Should you email this form, it will not be processed.

Please send this form to our office by mail or fax (204-774-0750), or telephone the Finance Department at 204-774-4344.