

Credit Card Payment Form

Last Name: _____

Given Name(s): _____

CPSA Registration or CPSA tracking number: _____

Complaint/Facility/File # (if applicable): _____

Reason for Payment: _____

To pay by VISA, MasterCard or American Express complete and forward the following information to the College of Physicians & Surgeons of Alberta:

- VISA
- MasterCard
- American Express

Card Number: _____

Expiry Date (MM/YY): _____

CVV: _____

Cardholder Name (Please Print): _____

Cardholder Signature: _____

This Credit Card Payment Form will be destroyed immediately following processing.