



Credit Card Authorization Form

Date: _____

Payor Information:

SCPP Member # (if applicable): _____

Name: _____

Company: _____

Address: _____

City: _____

Province: _____

Postal Code: _____

Phone: _____

Email Address: _____

Payment Information:

Payment for: _____

Invoice # (if applicable): _____

By filling out and submitting this form, I declare that I am aware of and accept the 1.75% credit card payment surcharge to help cover the cost of secure and convenient payment service.

Invoice Amount (inc. tax)	1.75% Credit Card Surcharge	Total Amount to be Charged

Amount to Charge: \$ _____	<input type="radio"/> Visa	<input type="radio"/> MasterCard
Card Holder Name: _____		
Credit Card #: _____		
CSV (3-Digit Authorization Number on back): _____	Expiry: _____	
Signature of Authorization: _____		

We will only use the information collected on this form to process your credit card payment. We will not use or disclose your information for any other purpose. We will securely retain your payment information for the shortest duration required in compliance with our privacy policy and legislative requirements.

Email completed form to receivables@saskpharm.ca or fax to 306-584-9695

FOR OFFICE USE ONLY
Receipt #: _____
Batch #: _____
Date: _____
PSI Gate: _____
Global: _____
Authorization: _____