Comhairle na nDochtúirí Leighis
Medical Council

PAYMENT BY CREDIT CARD

PLEASE COMPLETE EACH BOX AND WRITE LEGIBLY IN BLOCK CAPITALS

Registration Number: _____

Doctor's Name: _____

Credit Card: **Visa** ☐ **Mastercard** ☐

Visa/ MasterCard No.																	Exp Date				

CVV			

(Last 3 digits on back of card)

Laser card No.																			Exp Date			

Name of credit/laser card holder: _____

Signature: _____ **Date:** _____

Amount to be debited:
(A fee of 2% will apply to all VISA and MASTERCARD payments
And €0.25 for all LASER and VISA DEBIT transactions)

€

Reason for payment: _____

FINANCE DEPARTMENT USE ONLY

Date Processed: _____
Processed by: _____
Visa/Mastercard/Laser _____ Date _____