



PHYSICIAN / VENDOR PAYMENT FORM

LAST NAME: _____ FIRST NAME: _____

Please select one:

I prefer cheques paid to my Corporation Yes or No

If **YES**, please complete:

CORPORATION NAME: _____

DATE OF INCORPATION: _____ BUSINESS NUMBER _____
(YYYY/MM/DD) (i.e. 11511 0234 RT0001)

ADDRESS: _____

CITY: _____ PROV: _____ POSTAL CODE: _____

If **NO**, please complete:

S.I.N. # _____

ADDRESS: _____

CITY: _____ PROV: _____ POSTAL CODE: _____

Date _____

Signature _____

Please return this completed form to Chastity Saudino, LEG Payment Support
Email – chastity.saudino@nbrhc.on.ca or Fax – 705-495-7956