

Statement of Services Rendered

Service Performed By: *(Please Print)*

*Name _____	Facility # _____
Address of Payee _____	Complaints # _____
Postal Code _____	

Payment Method:

Electronic Funds Transfer (EFT) <input type="checkbox"/>	New (Complete EFT Direct Bank Deposit Authorization) <input type="checkbox"/>
Cheque <input type="checkbox"/>	Existing <input type="checkbox"/>

Payment To Be Made To:

Expenses	Honorarium	
<input type="checkbox"/>	<input type="checkbox"/>	Self (if so, please provide social insurance #) _____
<input type="checkbox"/>	<input type="checkbox"/>	Professional Corporation (if so, please provide GST #) _____
<input type="checkbox"/>	<input type="checkbox"/>	Provide Full Name of Professional Corporation _____
<input type="checkbox"/>	<input type="checkbox"/>	Other (Identify) _____

Note: If no selection is made, payment will be issued to the individual

Nature of Services Rendered:

* Committee Name/Description _____

* Date(s) of Services Rendered _____ Place _____

Claim for Expenses <i>(receipts required)</i>		For Office Use Only	Vendor ID
Air Fare	\$		<i>Sub Account</i>
Car (Return) Kilometers	\$		
Taxis	\$		
Parking	\$	5760	
Meals	\$	5520	
Accommodation	\$	5210	
Sundry (Specify)	\$	5720	
Total Expense Claim ➔	\$	Total Expenses \$	
Claim For Honorarium			Vendor ID
Number of Days Of Meeting		5610	
Rate Per Day	\$	5040 CPP	
	\$	5611 GST	
Total Honorarium Claim ➔	\$	Sub-Total \$	
* Signature of Claimant	X	3060 Tax	
		3070 CPP	
Approved by	X	_____/_____/_____ mm/dd/yyyy	Total Honorarium \$

Pink copy – retain for your records

White & yellow copies – forward to College office

FIELDS MARKED BY * NEED TO BE FILLED IN TO ENSURE PROMPT PROCESSING

To serve the public and guide the medical profession.