Clear Form Print Form

College of Respiratory Therapists of Ontario

Ordre des thérapeutes respiratoires de l'Ontario

PAYMENT Form

1. PERSONAL / CONTACT INFORMATION

FIRST NAME SURNAME

CRTO Reg. No. (if applicable)

APT. NO. STREET ADDRESS

CITY PROVINCE

POSTAL CODE COUNTRY

EMAIL

PHONE NUMBER

2. PAYMENT INFORMATION

Purpose: ☐ Registration Fee ☐ Assessment Fee ☐ Other:

Payment Amount: $ ☐

Method of Payment:

☐ Cheque ☐ Money Order (payable to the CRTO)

☐ Online/Tele Banking (please use your CRTO registration number as the account number)

Bank Name _____ Trans. Date (MM/DD/YYYY) _____ Ref. No. _____

☐ Visa ☐ Master Card

Card Number Expiry Date

SIGNATURE _____ NAME ON CARD _____

SUBMIT YOUR PAYMENT TO:
CRTO, 180 Dundas St. W. Suite 2103 Toronto, ON M5G 1Z8
FAX: 416-591-7890
QUESTIONS:
TEL: 416-591-7800 or toll free 1-800-261-0528, EMAIL: walsh@crto.on.ca web www.crto.on.ca

OFFICE USE ONLY							RECEIVED DATE	AUTHORIZATION NO.	COMMENTS