Protected B (When Complete)

Advance Payment Details for Drug Submissions and Master Files

Submission Payment

Product Name

Company Name

Master File Payment

MF Name

MF Number *(if applicable)*

Company Name

Contact Name

Phone Number

International

This form contains payment information which should not be included within an electronic submission, as the information cannot be deleted and will remain as part of the submission on record. As such, please mail or fax this form separately to the Office of Submissions & Intellectual Property, ATTN: Cost Recovery. Office of Submissions & Intellectual Property, Therapeutic Products Directorate, Health Canada, 101 Tunney's Pasture Driveway, Finance Building, Address Locator 0201A, Ottawa, Ontario K1A 0K9. Fax Number: 613-941-0825.

Bank Wire

Date the funds were wired (YYYY-MM-DD)

Amount of money wired (CAD)

Name of the bank the funds were sent from

A copy of the transaction receipt from your bank is enclosed

Cheque / Bank Draft

Cheque / Bank Draft number

Money Order

Credit Card *(All credit cards must be equipped to make international third party transactions.)*

Company Name

File Name / Product Name

Credit Card Type

Card Holder's Name

Credit Card Number (full number)

Credit Cardholder's Address

Credit Cardholder's Telephone Number International

Credit Card Expiry Date (YYYY-MM)

Mandatory, if using Credit Card option: Authorized Signature___________________________

Please Apply the Following Credit towards the Drug Submission Review Fee/Master File Fee

Customer / Client Account Number

Company Name

Existing Credit Amount

Existing Credit amount to be Applied

Payment of Invoice(s) / Statement Balance through a Financial Institution

Customer Account Number
e.g., DRSE0000

Client Reference Number Invoice(s)

Number to be paid

Date Funds Paid: YYYY-MM-DD

Amount of Funds Paid (CAD)

Health Canada use only

SAP Invoice Number ________________

Customer Account Number _________________

SAP Order Number ________________

Control Number ________________

Date (YYYY/MM/DD) ___________________