Advance Payment Details for Master Files for Human and Disinfectant Drugs, and Certificate of Supplementary Protection Applications

Contact Information

Contact Name: _____

Phone Number: _____

International: _____

Master File (MF) Payment

MF Name: _____

MF Number (if applicable): _____

Company Name: _____

Certificate of Supplementary Protection Application Payment

Applicant Name: _____

Patent Number: _____

New Drug Submission Number: _____

Customer Number: _____

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 courier or fax this form separately to: Office of Submissions & Intellectual Property, Resource Management and Operations Directorate, Health Canada, Address Locator: 1908A, 8th floor, Room 811A, Jeanne Mance Building, 200 Eglantine Driveway, Ottawa, Ontario, K1A 0K9. ATTN: Cost Recovery. 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 / Money Order

Cheque / Bank draft number: _____

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:_____

Number International: _____

Credit Card Expiry Date (YYYY-MM): _____

Mandatory, if using Credit Card option:

Authorized Signature: _____

Please Apply the Following Credit

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): _____