Protected B (When Complete)

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

Contact Information

Contact Name: _____

Phone Number: _____

International: _____

☐ Submission Payment

Product Name: _____

Company Name: _____

☐ 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: _____

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 / 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): _____