

INFORMATION REQUIRED		
Vendor Name:		Date:
Contact Name(s):		Phone Number:
Address:		Fax Number:
		Email:
WCBNS ID Number(s): i.e. PHC-123 <i>(Please include a list of WCBNS ID numbers if you want this banking information used for more than 1 clinic)</i>		
TO PROCESS EFT PAYMENTS WE REQUIRE THE FOLLOWING BANKING INFORMATION		
Bank Name:		
Bank Address:	City, Province:	Postal Code:
Bank Account Name:	Bank Number (also referred to as Financial Institution ID):	
Transit Number:	Account Number:	
Authorized Signature(s):		
x		x

If possible, please provide a "VOID" cheque with your request form.

CANADIAN BANK /CREDIT UNION NAME		001
		YYYY MM DD
Pay to the order of: _____	\$ _____	
_____	/100 DOLLARS	
Memo _____		

VOID

- 001
Cheque Number
 (not required)
- 12345
Transit Number
 Always 5 Digits
- 678
Bank Number
 Always 3 Digits
- 99999 99
Account Number
 Can be 7-12 Digits

Please fax this completed form to **1-902-491-8720**. Attention: **Financial Services**.
This fax number is not checked for claim-related documents