

Freedom of Information
The Royal Children's Hospital
50 Flemington Road
Parkville Vic 3052
tel: 9345 5132/9345 9464
email: foi@rch.org.au

Tax Invoice/Receipt
ABN 35655720546



FREEDOM OF INFORMATION APPLICATION FEE (non-refundable)
AMOUNT PAYABLE \$31.80

Patient's Name: _____

Payment by Credit Card (1.5% surcharge)

Cardholder's Name: _____ (please print)

Choose: Mastercard / Visa / Bankcard

Card Number: ____ / ____ / ____ / ____

Expiry Date: ____ / ____

Cardholder's signature: _____

Payment by Electronic Fund Transfer (EFT)

Your reference must state: FOI application fee and include the patient's name

Please forward a copy of the payment advice with your application

Bank: **Commonwealth Bank**

BSB: **063 010**

Account No: **1094 5576**

Account Name: **Royal Children's Hospital**

Cheque - attached

Money Order - attached

Upon payment this document becomes a Tax Invoice/Receipt

Please keep a copy as no further receipts will be issued

Office Use ONLY

Cost Centre R1713 Account code 57506

FOI number _____

Cashiers, please email confirmation of payment to foi@rch.org.au