

ROYAL CHILDREN'S HOSPITAL
FREEDOM OF INFORMATION

**APPLICATION FEE
REMITTANCE ADVICE**

Patient's Name: _____

Cardholder's Name: _____ (please print)

Choose: Mastercard / Visa / Bankcard

Card Number: _ _ _ _ _ / _ _ _ _ _ / _ _ _ _ _ / _ _ _ _ _

Expiry Date: _ _ / _ _

Cardholder's Signature: _____

Amount \$24.40

Date: _ _ / _ _ / _ _