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Pre-authorized Payment Cancellation Form

Please complete the information below and email or fax the form to BCCNM Finance.

Personal information

Last name _____ First name _____ BCCNM ID _____

Address (Apt/Box/#/Street) _____ City/town _____

Province/State _____ Country _____ Postal code/zip code _____

Telephone _____ Email _____

Cancellation date

Please stop all pre-authorized debits from my account beginning _____

Choose one option:

Leave credit on my account to be used towards renewal fees Issue refund for unused PAP payments

Authorization

I, _____, authorize the BC College of Nurses and Midwives to cancel my authorization to issue pre-authorized debits from my account. I acknowledge that this cancellation does not terminate any other obligation that we may have with the college.

Signature of account holder

Signature of joint account holder (if applicable)

Name of account holder (please print)

Name of joint account holder (please print)

Date

Date

NOTE: Please allow up to 30 days for this cancellation to take effect.