St. Simon the Apostle Primary School

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NAB TRANSACT (CREDIT CARD PAYMENT) REQUEST

Name**:** _____ Acc No: _____
(office use only)

Name & Year level of each Student: _____

_____

_____

Please complete card details and sign below.

Tick one box only MASTERCARD ☐ VISA ☐

CARD NUMBER: — — — — — — — — — — — — — — — —

CARD EXPIRY DATE: ___/ ___

Name on Card: _____

Signed: _____ Date: _____

Contact Phone Number: _____

Frequency:

☐ Fortnight from: 3rd Feb to 24th November (22 payments)
OR

☐ Month A from: 3rd Feb to 3rd November (10 payments)
OR

☐ Month B from: 24th Feb to 24th November (10 payments)
OR

☐ Quarterly 10th March, 9th June & 8th Sept. (3 payments)
OR

☐ Full Payment 24th February (1 payment)

AMOUNT: $ _____ to be deducted as per frequency above

Office use only

DATE	COMMENTS/ CHANGES