



Mail Order Form

Please debit by *(tick the appropriate box)*

Visa

Mastercard

Amex

CSV

Card number

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Name of Cardholder: _____
(Please write in capital letters)

Signature: _____ **Expiry Date:** _____

Particulars of Patient

Name of Patient: _____
(Please write in capital letters)

NRIC No./ Passport No.: _____ **Total amount \$S** _____