



MEDICINE HAT PUBLIC SCHOOL DIVISION

601 – 1st Avenue S.W., Medicine Hat, Alberta T1A 4Y7 Phone: (403) 528-6714 Fax: (403) 529-5339

Pre-Authorized Debit (PAD) Agreement – Hockey Academy

1. Customer Information (Please Print Clearly)

Name: _____

Street Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone Number: _____

2. Bank Account Information – please provide a blank cheque marked “VOID” or Direct Deposit form from your bank

Account Number:

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Branch Transit Number:

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Financial Institution Number:

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Chequing Account:

Savings Account:

Financial Institution: Name: _____

Branch Address: _____

3. Pre-Authorized Debit (PAD) Details (Please Print Clearly)

You, the Payer, authorize the Medicine Hat Public Board of Education operating as the [Medicine Hat Public School Division](#) to debit the bank account identified above for the amount of **\$ 225.00** on the **first business day of every month** from **Sept 2026 to Feb 2027** (6 payments). The total of all payments is **\$1,350.00**.

You, the Payer, may revoke your authorization at any time in writing subject to providing notice of 30 days. For more information on your right to cancel a PAD Agreement or to obtain a sample cancellation form contact your financial institution or visit www.cdnpay.ca.

Signature of Account Holder: _____

Signature of Joint Account Holder (if applicable): _____

Name: _____
(Please Print Clearly)

Date: _____
(Please Print Clearly)

Name: _____
(Please Print Clearly)

Date: _____
(Please Print Clearly)

You have certain recourse rights if any debit does not comply with this agreement. For example, you have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD Agreement. To obtain more information your recourse rights, contact your financial institution or visit www.cdnpay.ca.

4. Office Use Only

Date Received: _____ Student Name: _____

Form Received by (Name) _____ School: _____

