Ontario

Ministry of Health
and Long-Term Care

Assistive Devices Program
Confirmation of Payment Instructions

I/We authorize my/our payments be forwarded by deposit directly into the following account:
(Please attach a blank voided cheque)

Financial Institution Information

Branch Number*	Institution Number*	Account Number*

* from the MICR encoding on the cheque

Name of Financial Institution

Address

Unit Number	Street Number	Street Name	PO Box

City/Town	Province	Postal Code

Vendor Information

Vendor Name	Vendor Number

Address

Unit Number	Street Number	Street Name	PO Box

City/Town	Province	Postal Code

Signature

I/We confirm that the above information is correct.

Name	Authorized Signature	Date (yyyy/mm/dd)
Name	Authorized Signature	Date (yyyy/mm/dd)

 © King's Printer for Ontario, 2022 Disponible en français