

**PRE-AUTHORIZED DEBIT (PAD) AGREEMENT**

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| **INFORMATION** | | | | | | | | | | |
| Child’s First Name: | | |  | | | | Child’s Last Name: | |  | |
| Parent’s First and Last Name: | | | | | |  | | | | |
| Mailing Address: | | | |  | | | | | | |
| City: |  | | | | Province: | |  | | Postal Code: |  |
| Cell Phone | |  | | | | | E-mail: |  | | |

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| **BANKING ACCOUNT INFORMATION** | | | | | |
| Name of Financial Institution: | | |  | | |
| Branch Address: | Enter full branch address, including postal code | | | | |
| Deposit Account Number: | | |  | | |
| Branch Transit Number:  *(\*5 digits)* | | Enter 5 digits | | Financial Institution Number  *(\*3 digits)* | Enter 3 digits |
| **\*\*Submit a void cheque with the form or scan a void cheque and email it to us along with the form\*\*** | | | | | |

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| **PRE-AUTHORIZED DEBIT (PAD) DETAILS** | | | | | | | | | |
| You the Payor authorize Toronto Aspirals Gymnastics Centre to debit the bank account identified above, as per the schedule below. You the Payor may revoke your authorization at any time, subject to providing a written notice of 30 days. To obtain sample cancellation form, or for more information on your right to cancel a PAD Agreement, contact your financial institution or visit [www.cdnpay.ca](http://www.cdnpay.ca) | | | | | | | | | |
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|  | | | | | | | | | |
| Signature of Account Holder  Name of Account Holder. | | | | Signature of Joint Account Holder (if applicable)  Name of Joint Account Holder (if applicable) | | | | | |
| Name (please print)  Click or tap to enter a date. | | | | Name (please print)  Click or tap to enter a date. | | | | | |
| Date | | | | Date | | | | | |
| 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 consistent with this PAD Agreement. To obtain more information on your recourse rights, contact your financial institution or visit [www.cdnpay.ca](http://www.cdnpay.ca) | | | | | | | | | |
| **PAYMENT SCHEDULE**  ***for office use only*** | | | | | | | | | |
| Date: |  | Amount: |  | |  | Date: |  | Amount: |  |
| Date: |  | Amount: |  | |  | Date: |  | Amount: |  |
| Date: |  | Amount: |  | |  | Date: |  | Amount: |  |
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| Date: |  | Amount: |  | |  | Date: |  | Amount: |  |
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**When the form is complete, drop off at:**Toronto Aspirals Gymnastics Centre | 6 Bradwick Dr., Concord, ON L4K 2T3 | 905-760-0092 | info@aspirals.ca