DIRECT DEBIT REQUEST **Form** Approved	MEDILINK Advanced Professional Systems Pty Ltd T/a Medilink PO Box 7296, EAST BRISBANE Ph: 1800 623 633 Fax: 073392 1108

Request and Authority to debit the account named below to pay Advanced Professional Systems Pty Ltd (MEDILINK)

Request and Authority to debit	**Practice name:** _____ **Postal** address: _____ **Your Given Names or ABN/ACN:** _____ "you" **request and authorise** Advanced Professional Systems Pty Ltd T/A MEDILINK & user id 416127 **to arrange, through its own financial institution, a debit to your nominated account the amount** MEDILINK**, has deemed payable by** *you.* This debit or charge will be made through the Bulk Electronic Clearing System (BECS) from *your* account held at the financial institution (Bank) you have nominated below and will be subject to the terms and conditions of the Direct Debit Request Service Agreement.
Insert the name and address of Bank at which account is held	**Bank name:** _____ **Address:** _____
Insert details of account to be debited	**Account name:** _____ **BSB number (Must be 6 Digits):** |___|___|___| - |___|___|___| **Account number:** |___|___|___|___|___|___|___|___|___|
Acknowledgment	By signing and/or providing us with a valid instruction in respect to your Direct Debit Request, you have understood and agreed to the terms and conditions governing the debit arrangements between you and **MEDILINK** as set out in this Request and in your **Direct Debit Request Service Agreement**.
Insert your signature and address	**Signature**_____ (If signing for a company, sign and print full name and capacity for signing eg. director) **Address**_____ **Email** _____ **Date** ___ / ___ / ___ **Phone:**
Second account signatory (if required)	**Signature**_____ (If signing for a company, sign and print full name and capacity for signing eg. director) **Email** _____ **Date** ___ / ___ / ___ **Phone:**

Please sign then Fax this completed request form to MEDILINK: 07 3392 1108. Thank you.