



St. Simon the Apostle Primary School

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2024 NAB TRANSACT (CREDIT CARD PAYMENT) REQUEST

Name: _____ Debtor ID: _____
(office use only)

Name & Year level of each Student: _____

Frequency:

- Fortnight from: 2nd Feb to 22nd November (22 payments)
OR
- Month A from: 2nd Feb to 2nd November (10 payments)
OR
- Month B from: 23rd Feb to 23rd November (10 payments)
OR
- 3 Payments 8th March, 7th June & 6th Sept. (3 payments)
OR
- Full Payment 23rd February (1 payment)

Please circle:
Weekly
Fortnightly
Monthly

Other Start date: ___/___/___ Number of payments: _____ Frequency: _____

AMOUNT: \$ _____ to be deducted as per frequency above

Office use only

DATE	COMMENTS/ CHANGES

Please complete card details and sign below.

Tick one box only MASTERCARD VISA

Name on Card: _____

Signed: _____ Date: _____

Contact Phone Number: _____

CARD NUMBER: - - - - - - - - - - - - - - - -

CARD EXPIRY DATE: ___/___