SPFA PCP RENEWAL COSTS FORM

Name of Payee: *(please print)* _____

Company Name: _____

All states you do work in:_____

Certified Individual Name(s)	Total Renewal Fees Paid
	$
	$
	$
	$
	$
	$
	$
	$
TOTAL	$

❑ My check for total payment, made out to SPFA PCP, is enclosed.

❑ VISA ❑ MasterCard ❑ American Express

Credit Card Number:___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___

Expiry Date: ___|___ CSV Code: (Amex 4 digits) _____ Card Zip Code: _____

Cardholder's Name:_____

Authorized Signature: _____

Please forward this form and payment to the SPFA PCP Office:
1600 Boston-Providence Hwy | Walpole, MA | 02081
Fax: 1-866-956-5819 or e-mail: admin@spfapcp.org Questions: 1-866-222-5000