

STATEMENT OF CONTRIBUTION



TO BE COMPLETED AND SIGNED BY FINANCIAL INSTITUTION
AND ATTACHED TO PHYSICIAN'S CPRSP APPLICATION FORM

Note: This form to be used only when an income tax receipt copy is not available.

(Please print or type)

Name of Physician: _____

Name of RSP/IPP Trustee: _____

Account Number _____

Type of Account: [] Personal RSP [] Spousal RSP [] IPP _____
Plan Registration Number

Contributions made to date by the
physician for the 2008 taxation year: \$ _____
(THIS AMOUNT MUST NOT INCLUDE ANY PREVIOUS DEPOSITS BY THE BCMA)

Date contributions(s) made: _____

I hereby certify that the above information is truthful and accurate.

Signature of Representative of RSP/IPP Trustee

Name of Representative of RSP/IPP Trustee (please print)

Title

Date

Telephone Number

Email Address

**PLEASE ATTACH THIS STATEMENT TO THE CPRSP APPLICATION FORM
STATEMENTS SUBMITTED SEPARATELY WILL TAKE LONGER TO PROCESS**