



DE LA SALLE
MEDICAL AND HEALTH SCIENCES INSTITUTE

ACADEMICS
COLLEGE OF PHARMACY

CPD-001: Payment order form

Date: _____

To: CASH SERVICES
De La Salle Medical and Health Sciences Institute

Name: _____

Section/ Address: _____

Payment details:

OR Number: _____ Date: _____

Endorsed: _____
Faculty in charge (Print name and sign)

Approved: _____
Dean, College of Pharmacy



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