

SEPA Direct Debit Mandate



Creditor Identifier: IE14ZZZ111427

Legal Text: By signing this mandate form, you authorise (A) Ambermed Limited to send instructions to your bank to debit your account and (B) your bank to debit your account in accordance with the instruction from Ambermed Limited.
As part of your rights, you are entitled to a refund from your bank under the terms and conditions of your agreement with your bank. A refund must be claimed within 8 weeks starting from the date on which your account was debited. Your rights are explained in a statement that you can obtain from your bank.
Please complete all the fields below marked *

Please use CAPITAL letters.

*Your Name :

*City/postcode: *Country:

*Account number (IBAN):

*Swift BIC:

Creditors Name:	Ambermed Limited
Creditors Address Line 1:	The Mill Business Centre
Address Line 2:	Croom, Co. Limerick
Country:	Ireland

*Type of payment: Recurrent **or** One-Off Payment (Please tick v)

*Date of signing (dd/mm/yyyy):

*Authorised Signature(s):