

POST LEAVING CERTIFICATE GRANT BANK MANDATE

PLEASE RETURN THIS FORM TO CITY OF GALWAY VEC, ISLAND HOUSE,
CATHEDRAL SQUARE, GALWAY

STUDENT NAME: _____

STUDENT ADDRESS: _____

DATE OF BIRTH: _____

TELEPHONE NO. _____

AWARDING BODY: _____

NAME OF COLLEGE: _____

COURSE TITLE: _____

ACCOUNT NAME: _____

BANK: _____ BRANCH: _____

ACCOUNT NUMBER:

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(Not card no.)

BANK SORT CODE:

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(Bank account must be in students name only, it cannot be a third party account)

SECTION C - TO BE COMPLETED BY YOU

SIGNED: _____ DATE: _____

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