FONDATION DE L'HÔPITAL ST. MARY | ST. MARY'S HOSPITAL FOUNDATION

DONATION FORM

Charitable organization # 11918 9108 RR0001

DONOR INFORMATION:

*(*Required for tax receipt)*

Full Name*: _____ Title: _____

Company Name *(if applicable)*: _____

Street Address*: _____

City*: _____ Province*: _____ Postal Code*: _____

Phone: _____ Email: _____

I WOULD LIKE TO DONATE:

Monthly donation: ☐ $100 ☐ $50 ☐ $25 ☐ Other $ _____

Single donation: ☐ $1,000 ☐ $250 ☐ $100 ☐ $50 ☐ $25 ☐ Other $ _____

METHOD OF PAYMENT:

☐ Credit Card: ☐ MasterCard ☐ Visa ☐ Amex

Cardholder's Full Name: _____

Credit Card #: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ Expiry Date: mm / yy

☐ Cheque *Single donation* - please make the cheque payable to **St. Mary's Hospital Foundation**

Monthly donation - please call our Foundation office at 514-734-2694

☐ Cash

GIFT DESIGNATION:

☐ Please direct my gift to St. Mary's area of greatest need

☐ Other *(specify)*: _____

MY GIFT IS ☐ IN MEMORY OF: ☐ IN HONOUR OF: _____

MESSAGE: _____

PLEASE SEND ACKNOWLEDGEMENT OF MY GIFT TO: LANGUAGE: ☐ ENGLISH ☐ FRANÇAIS

Full Name: _____ Title: _____

Street Address: _____

City: _____ Province: _____ Postal Code: _____

Phone: _____ Email: _____

heartfelt thanks

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