

PERSONAL INFORMATION:

For income tax receipting purposes

Mr. Mrs. Dr. Ms. Mr. & Mrs. Other Title: _____

Donor Name

Spouse/Partner Name

Street AddressCity/Town.....

Province.....Postal Code.....Phone (mobile).....

E-Mail Address Phone (home).....

GIFT INFORMATION

Gift Amount \$ _____ This is a one-time gift

I would like to give the above amount monthly ***

PROCESSING DETAILS

Cardholder's Name _____

Card Type: VISA MasterCard American Express

Card Number _____ CVC# _____ Expiry Date ____/____/____
3-digit number

I have enclosed a cheque with this donation form

To help us better serve our community, please indicate what inspired you to give today:

.....

IS YOUR GIFT A MEMORIAL AND HONOURARIUM DONATION? If yes, complete below.

MEMORIAL TRIBUTE _____
Name of tribute (deceased person)

IN HONOUR of _____
Name / Record reason for honouring this person: Birthday, anniversary, etc.

Please provide contact information for the memorial gift next-of-kin OR donation honouree you would like us to notify of your gift. (Gift amount will remain confidential)

Name

Mailing Address

and/or E-Mail Address Phone

***If you have used this form to become a monthly donor, thank you. You will be receipted at year-end for your year's gift total. You may adjust or stop your gifts at any time by contacting the Foundation office at 905-985-7321 X 5581 or ragnoluzzi@lakeridgehealth.on.ca

Port Perry Hospital Foundation Charitable Registration Number 89145 0843 RR0001

THANK YOU for your support of health care for our community!