PORT PERRY HOSPITAL Foundation

DONATION FORM

Please return to 451 Paxton Street, Port Perry, ON L9L 1L9

PERSONAL INFORMATION:

For income tax receipting purposes

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

Donor Name ……

Spouse/Partner Name ……

Street Address ……City/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 45580 or licochrane@lh.ca.

Port Perry Hospital Foundation Charitable Registration Number 89145 0843 RR0001

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