



Please print this form and mail or fax to the above address or fax number

Please check one:

- Monthly Single Gift Gift In Memory Gift In Honour

GIFT INFORMATION

Name: Organization (if applicable) Address: City: Province: Postal Code: Phone: Home Business Gift Amount: \$

MONTHLY DONATION PROGRAM*

- I would like to the donate \$ monthly by credit card. I will provide my credit card information in the GIFT INFORMATION box below. Please withdraw my monthly gift from my bank account* — I have enclosed a VOID cheque for banking information and filled out the GIFT INFORMATION box below.

*Monthly donations are charged on the 15th of each month.

TRIBUTE: MEMORIAL or IN HONOUR PROGRAM

Please fill out if applicable: Person's Name (for whom gift is being given): Please send Notification to: Address: City: Postal Code:

Payment information shredded after being processed

Please select: Visa Mastercard American Express Cheque enclosed, payable to Milton District Hospital Foundation Credit Card #: Expiry Date

Signature: Date: