DONATION FORM

Please complete the information below.

PLEDGE TYPE

❑ Monthly* ❑ One-Time

*Monthly donations to be processed on the _____ day of each month.

PERSONAL INFORMATION

Title: ❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms. ❑ Other _____

First Name: _____ Last Name: _____

ADDRESS INFORMATION

Company Name: _____

Apt/Box/Floor/Suite: _____ Address:_____

City/Town: _____ Prov. ____ Postal Code: _____

Email: _____ Phone (H): _____

Phone (B): _____ Ext. _____ Fax: _____

DONATION INFORMATION

❑ $25 ❑ $50 ❑ $75 ❑ $100 ❑ Other _____

Method of Payment: ❑ Credit Card ❑ Cash ❑ Cheque*

❑Visa ❑ MasterCard Name of Credit Card: _____

Credit Card No.: _____/_____/_____/_____ Expiry Date: _____/_____ (MM/YY)

Signature: _____

(*Make cheques payable to Northwest Health Foundation)

Is this a Tribute Gift? ❑ In Honour of ❑ In Memory of*

Name: _____

*Please provide next of kin contact information for Memorial Gifts.

Title: ❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms. ❑ Other _____

First Name: _____ Last Name: _____

Apt/Box/Floor/Suite: _____ Address: _____

City/Town: _____ Prov. ____ Postal Code: _____

Email: _____ Phone: _____

The Northwest Health Foundation issues tax receipts for gifts $25 or more. Monthly donations are receipted annually.

THANK YOU FOR DONATING TO THE NORTHWEST HEALTH FOUNDATION!

Registered Charitable No.: 89069-1199 RR0001

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