



GRATEFUL PATIENT DONATION FORM



Please complete and send this form to the Stevenson Memorial Hospital Foundation at foundation@smhosp.on.ca

DONOR INFORMATION (to be completed by Donor)

First Name: _____	Last Name: _____	Spouse Name: _____
Organization (if applicable): _____		
Address: _____		
City: _____	Province: _____	Postal Code: _____ Country: _____
Phone (Day): _____	Phone (Alternate): _____	Email: _____

WHERE WOULD YOU LIKE TO DESIGNATE YOUR GIFT?

<input type="checkbox"/> Redevelopment Project	<input type="checkbox"/> Other (please indicate designation) _____
--	--

STAFF MEMBER(S)/DEPARTMENT INFORMATION

<p>This donation is in recognition of (staff member name(s)/department):</p> <p>_____</p> <p>_____</p> <p>Reason for donation (optional):</p> <p>_____</p> <p>_____</p> <p>_____</p>
--

PAYMENT INFORMATION

<input type="checkbox"/> One-time Payment	<input type="checkbox"/> Monthly		
Gift Amount: \$ _____	Preferred Process Date: _____		
Card Type: <input type="checkbox"/> VISA	<input type="checkbox"/> MasterCard	<input type="checkbox"/> American Express	<input type="checkbox"/> Cheque
Card Number: _____	Expiry Date: _____	CWV: _____	

Signature: _____

Date: _____

Privacy Policy: Stevenson Memorial Hospital Foundation is strongly committed to protecting the privacy and confidentiality of your personal information. We value your trust and recognize that maintaining this trust requires that we be open and accountable in our treatment of the personal information that you choose to share with us. We do not lend, rent or sell your information. Personal information collected by the Foundation is kept in strict confidence.

THANK YOU

Charitable Registration No. 119173235 RR0001