



MONTHLY DONATION FORM



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

By joining us as a Monthly Partner, you will unite with others in supporting the Foundation's Because of YOU Campaign, which supports the Stevenson Memorial Hospital redevelopment project.

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: _____

PAYMENT INFORMATION

Gift Amount \$ _____
<input type="checkbox"/> Credit Card
Card Type: <input type="checkbox"/> VISA <input type="checkbox"/> MasterCard <input type="checkbox"/> American Express
Card Number: _____ Expiry Date: _____ CVV: _____
<input type="checkbox"/> Direct Deposit
Institution Number: _____ Transit Number: _____
Account Number: _____

Please note:

- A tax receipt will be sent to you at year's end.
- Donations will end at any time when revoked by donor in writing to the Foundation.
- Donations to start on the 15th of the month following the date below.

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