



ONE-TIME 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) _____
This gift is in honour of/in memory of/in celebration of (person's name) _____	

NEXT OF KIN/HONOUREE INFORMATION

Would you like us to send a notification to the Next of Kin or Honouree? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please provide Complete Name and Address of Next of Kin/Honouree (if unable to provide information, for Next of Kin, please name funeral home of service).
First Name: _____ Last Name: _____ Funeral Home: _____
Address: _____
City: _____ Province: _____ Postal Code: _____ Country: _____

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: _____	CVV: _____	

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