

## Join our family in making a monthly donation to the Carleton Place & District Memorial Hospital Foundation

Your support means that we are able to provide the vital and life-saving equipment needed for the many patients who walk through our doors each day. A monthly gift makes a **BIG** difference, a little bit at a time. Simply fill out the form below, return it to the Foundation Office and we'll be in touch!



Thank you, we truly appreciate your support!

## YES, I WANT TO SUPPORT MY HOSPITAL!

Name (First):	Name (Last):			
Address:				
City:	_ Postal Code:	Phone	Phone: 613	
Email:		<del></del>		
•	postage and we will sei	nd your receipt to you electronic	cally!	
Each month, I will give:				
$\square$ \$10 $\square$ \$25 $\square$ \$50	□ \$75 □	\$100  \text{\$150}	□ Other \$	
You have two options in m	aking your gift —	choose the one which w	orks best for you!	
Credit Card	OI	R 🗌 Direct Debi	it	
☐ Below is my credit card information		☐ Enclosed is my VOID cheque		
□ VISA □ MasterCard Expiry Date  Card #  3-diget CVV Code (back of card)		on my bank account through my financial institution on approximately the 15 <sup>th</sup> day of		
Signature		Date	End Date* *if applicable, otherwise n/a	

You may change the amount or cancel your monthly contribution at any time by notifying the CPDMH Foundation. At the end of the year, we will issue you an official receipt for the total amount of your donations.

Thank you for your support!

Our donor records are confidential. We do not share our lists. Charitable Registration #86610 5398 RR0001