YOUR DONATION to the Carleton Place & District Memorial Hospital Foundation *COUNTS!*

Please take a moment and reflect on what our community would be like without our hospital. Each year the Foundation raises funds to purchase needed equipment for our hospital and staff education to help provide YOU the best and highest quality of care close to home. Every gift you give to the Foundation impacts the quality of care we are able to provide.

Carleton Place & District Memorial Hospital FOUNDATION

One Time & Monthly Giving

We count on **YOU** and our community to help us provide quality and patient-focused care.
Join others in your community and help make a difference through your donation or monthly gift.
Thank you—YOUR donation *counts!*

Monthly giving is a tremendous way to ensure your gift works harder. It's the most effective way to provide steady, on-going funds to help the Carleton Place & District Memorial Hospital. Not only is a monthly debit amount a more manageable way to give, it saves administrative costs for envelopes and postage too!

☑ YES, I WANT TO SUPPORT MY HOSPITAL!

Please complete the information below in full and return to the Foundation Office.

Name: _____ **Address**:_____

City: _____ **Postal Code:** _____ _____ **Phone:** 613 - _____ - _____ **Email**: _____

This will save us a stamp as we can send your receipt to you electronically!!

You have several options in making your donation or monthly gift —choose the one which works best for you!

☐ *One Time Donation*

Yes, I would like to make a donation in the amount of $_____.___ to the CPDMH Foundation.

Enclosed is my cash, cheque, or I have completed the Credit Card information below for this donation amount...

☐ *Monthly Donation: Direct Debit*

Yes, I authorize CPDMH Foundation to withdraw the following amount from my **bank account** each month (12 per year).
I may change the amount or cancel my monthly contribution at any time by notifying the CPDMH Foundation.

☐ Each month, I will give: ☐ $5 ☐ $10 ☐ $25 ☐ $50 ☐ $100 ☐ Other $ _____

☐ I authorize the CPDMH Foundation to draw on my bank account through my financial institution on approx. the 15th of each month beginning: _____ Date _____ End Date*

**if applicable, otherwise n/a*

_____ Signature

☐ I have enclosed a cheque with VOID written across it for the CPDMH Foundation to arrange the monthly withdrawal from my bank account.

☐ *Monthly Donation: Credit Card*

Yes, I authorize CPDMH Foundation to withdraw the following amount from my **credit card** each month (12 per year).
I may change the amount or cancel my monthly contribution at any time by notifying the CPDMH Foundation.

☐ Each month , I will give: ☐ $5 ☐ $10 ☐ $25 ☐ $50 ☐ $100 ☐ Other $ _____

☐ VISA ☐ MasterCard ☐ American Express Card # _____ _____ _____ _____ Expiry Date ____/____

_____ Signature _____ Date

Thank you for your support! *Our donor records are confidential. We DO NOT share our lists.* **Charitable Registration #86610 5398 RR0001**
For monthly donors: At the end of the year, we will issue you an official receipt for the total amount of your donations.

Please return the following donation form to the Foundation Office:
Carleton Place & District Memorial Hospital Foundation | 211 Lake Avenue East, Carleton Place, ON, K7C 1J4
613-257-2200 x 856 | foundation@carletonplacehosp.com | www.carletonplacehospital.ca