



# DONATION FORM

(NOTE: All Fields \* must be completed)

INDIVIDUAL GIFT       ORGANIZATION GIFT (include contact person)      RE ID # \_\_\_\_\_

Mr.       Mrs.       Ms.       Dr.       Miss

Organization Name (if applicable): \_\_\_\_\_

First Name\*: \_\_\_\_\_ Last Name\*: \_\_\_\_\_

Suite/Unit/Apt \_\_\_\_\_ Street Address \*: \_\_\_\_\_

City\*: \_\_\_\_\_ Prov\*: \_\_\_\_\_ Postal Code\*: \_\_\_\_\_

Home Phone\*: \_\_\_\_\_ Cell Phone\*: \_\_\_\_\_

Email (Optional): \_\_\_\_\_

By completing this field, I agree to receive email communications from Scarborough and Rouge Hospital Foundation.

**DONATION AMOUNT\***: \_\_\_\_\_

<p><b>METHOD OF PAYMENT*</b></p> <p><input type="checkbox"/> <b>Cash</b></p> <p><input type="checkbox"/> Visa</p> <p><input type="checkbox"/> MasterCard</p> <p><input type="checkbox"/> Cheque (<b>PAYABLE TO SHN FOUNDATION</b>)</p>	<p><b>Credit Card Information:</b></p> <p>Card Number: _____</p> <p>Expiry Date: ____/____</p> <p>Cardholder's Name: _____</p>
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NOTES: \_\_\_\_\_

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