Lakeridge Health Foundation Monthly Giving Program

Complete this form and mail or fax it to Lakeridge Health Foundation. This could be the most important thing you do today!

PERSONAL INFORMATION

Name: _____

Address: _____

City: _____

Province: _____ Postal Code: _____

Phone Number: _____

Email: _____

PAYMENT INFORMATION

You will receive a single tax receipt for the total of your monthly donations after the December donation has been processed.

I would like to join Lakeridge Health Foundation's monthly giving program. Each month I wish to donate:

- ☐ $10 (32 cents/day)
- ☐ $15 (48 cents/day
- ☐ $20 (65 cents/day)
- ☐ I prefer to give $_____/month

☐ Deduct these donations from my chequing account on or around the 1st day of each month. I have enclosed a blank sample cheque marked "VOID"

OR

☐ Please charge the above amount to my credit card:

☐ Visa ☐ MasterCard ☐ Amex

Cardholder Name: _____

Card Number: _____

Expiry Date: _____

Signature: _____

NEW

☐ Please send my annual tax receipt by email.

For further information, or to speak with someone directly, contact **Carmen Brosseau, Development Officer** at **905-576-8711 ext. 2838** or email **cbrosseau@lakeridgehealth.on.ca**

* I understand that this agreement may be adjusted or cancelled at any time, subject to 5 business days' notice prior to the next processing date, by contacting Lakeridge Health Foundation at 905.576.8711 Ext 3811. I have the right to receive reimbursement for any debit that is not authorized. To obtain a sample cancellation form, or for more information on my rights to cancel a PAD Agreement, I may contact my financial institution or visit www.cdnpay.ca

1 Hospital Court, Oshawa, ON L1G 2B9 | 300 Gordon Street, Whitby, ON L1N 5T2
Phone: 905-433-4339 | Fax: 905-743-5306 | foundation@lakeridgeheath.on.ca
lakeridgehealthfoundation.com | Charitable registration #: 11924 9126 RR0001

Lakeridge Health Foundation