

Donation Form Page 1



Donor Information

Title: (Mr., Miss, Ms., Mrs. Dr.)

First Name: Initial(s): Last Name(s):

Street Address:

City: Province: Postal Code:

Telephone Number: Fax Number:

Home Email: Business Email:

Gift Information

Total Gift Amount: \$

- One time Recurring Monthly donation

Recognition Information

OR Anonymous

Please enter name as how you would like it to appear on all recognition material

Payment Information

Cheque - Please make your cheque payable to the *Cambridge Memorial Hospital Foundation*.

Visa MasterCard Amex

Card Number: _____ / _____ / _____ / _____ Expiry Date: ____/____

Void cheque attached for Electronic Funds Transfer (Monthly donation)

Please return to:

Cambridge Memorial Hospital Foundation

700 Coronation Boulevard
Cambridge, ON N1R 3G2

Tel: (519) 740-4966

Fax: (519) 740-4971

www.cmhfoundation.ca

Charitable Registration: 11882 6288 RR0001

Thank you for your generous support!

PAGE 2 - Additional Information for sending notifications:

The above donation is given In Memory In Honour
of the following person:

Please notify this person that a gift was made: (gift amount will not be shared)

Name(s): Company
Street Address:
City: Province: Postal Code:

Special Instructions or Comments

Please return both pages to:

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700 Coronation Boulevard
Cambridge, ON N1R 3G2

Tel: (519) 740-4966

Fax: (519) 740-4971

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Charitable Registration: 11882 6288 RR0001

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