



Monthly Giving Donation Form

DONOR INFORMATION:

NAME: _____ NAME OF BUSINESS: _____

TITLE: Mr. Mrs. Ms. Dr. Mr. & Mrs. Other _____

ADDRESS: _____

CITY: _____ PROV: _____ POSTAL CODE: _____

PHONE: _____ EMAIL: _____

MONTHLY GIFT AMOUNT: \$15 \$20 \$25 Other: \$_____

PLEASE START MY GIFT ON: 1st / 15th of _____ 20____

CHEQUE *Please enclose a void cheque*

CREDIT CARD: VISA MASTERCARD AMERICAN EXPRESS

CREDIT CARD #: _____ EXP. DATE: _____

SIGNATURE OF CARDHOLDER: _____

Please make my gift in Memory of:

We will send a card to the Next of Kin to acknowledge a donation has been made. Please complete the mailing information below:

Next of Kin name: _____

Address: _____

City: _____ Province _____

Postal Code: _____

My gift is to say thanks for great care:

Please let us know who made a difference in your stay at the hospital and we will provide them with a card and lapel pin to acknowledge this tribute:

_____ (person/department/team)

If you wish, include a note of thanks and we'll pass it along on your behalf.

Please send your completed form to:

PRHC Foundation
One Hospital Drive Peterborough, ON K9J 7C6

Phone: (705) 876-5000 Fax: (705) 876 5032
Website: www.prhcfoundation.ca
Email: foundation@prhc.on.ca

Thank you for your support!