



Donation/Pledge Card

Personal Info

Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Phone: _____ E-Mail: _____

I/we wish to contribute (please choose A or B)

A) a total gift of \$ _____ payable over 1 yr 2 yrs 3 yrs Monthly Program

- with payments made: Annually Semi-annually Quarterly Monthly Other _____

- with payments starting on: ____/____/____
(day / month / year)

- payable by: postdated cheques pre-authorized transfer To mail cheque upon reminder
(include a void cheque)

Visa MasterCard

Credit Card No. _____ Expiry date: _____

OR

B) one-time donation of \$ _____

- payable by: Cash Cheque

Visa MasterCard

Credit Card No. _____ Expiry date: _____

Please designate my gift to: the Greatest Need Fund Other _____

I would like my name to appear as _____
on published donor recognition lists.

_____ Date

_____ Signature

As an inspiration to others, I agree to allow my name to be added to the Foundation donor list and donor wall.

OR
 I wish my name to remain anonymous. (Your name will not be added to any donor list).

Gift in honour of _____

Birthday Anniversary Tribute Other _____

Please indicate name and address to send honorary acknowledgement

Closing our community's healthcare gap!

North Bay Regional Health Centre Foundation
50 College Drive, P.O. Box 2500 North Bay ON P1B 5A4
PHONE: 705-495-8125 FAX: 705-495-8121

CHARITABLE NO. BN 88773 1123 RR0001

- Please return this form with your donation
- Please write any additional comments or notes on the reverse side
- Please include postdated cheques or void cheque if applicable