Bowmanville HOSPITAL FOUNDATION

YOUR Foundation YOUR Hospital

Celebrating 40 Years

DONATION FORM

Please complete this form and return by mail or fax.

47 Liberty Street South, Bowmanville ON L1C 2N4
T: 905.623.3331 x 1881 F: 905.623.4001

PERSONAL INFORMATION:

☐ Mr. ☐ Mrs. ☐ Dr. ☐ Mr. & Mrs. ☐ Ms.

First Name _____ Last Name _____ Spouse Name _____

Organization *(If Applicable)* _____

Address _____

City _____ Province _____ Postal Code _____ Country _____

Phone *(Day)* _____ Phone *(Alternate)* _____ Email _____

FUND DESIGNATION:

Where would you like to designate your gift? ☐ Highest Priority ☐ Emergency ☐ Critical Care
☐ Palliative Care ☐ Eye Centre ☐ Diagnostic Imaging ☐ Surgery
☐ Other *(please indicate designation)* _____

This gift is in honour of/in memory of/in celebration of *(person's name):* _____

Would you like us to send notification to the Next of Kin or Honouree? ☐ Yes ☐ No
If Yes, please provide ***Complete Name & Address of Next of Kin/Honouree***
(if unable to provide information for Next of Kin, please name funeral home of service)

☐ Mr. ☐ Mrs. ☐ Dr. ☐ Mr. & Mrs. ☐ Ms.

First Name _____ Last Name _____

Address _____

City _____ Province _____ Postal Code _____ Country _____

Funeral Home _____

PAYMENT METHOD

☐ One Time Payment ☐ Monthly **Gift Amount $** _____

Cardholder's Name _____ Card Type: ☐ Visa ☐ MasterCard ☐ American Express

Card Number ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Expiry Date *(mmyy)* ☐☐ ☐☐ Card Security Code ☐☐☐

Further comments: _____

_____

_____

Thank You!

Charitable Registration Number: BN 11924 4903 RR0001