


YES! I want to Support The Ottawa Hospital Breast Health Centre!

Title: ☐ Mr. ☐ Mrs. ☐ Ms ☐ Dr.

Last Name: _____ First Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Phone Number: (Home) _____ (Business) _____ E-mail: _____

The Ottawa Hospital Breast Health Centre Honour Roll

Leadership gifts of $5,000 or more will be recognized on a special donor wall.
All gifts of $1,000 or more per year will be listed in our Leadership Registry (part of the Annual Report).

My Gift

For your convenience, a pledge can be made over 1-5 years. I wish to give:

☐ $1,000 per year for _____ years ($83.34 per month)

☐ $5,000 per year for _____ years ($416.67 per month)

☐ $10,000 per year for _____ years ($833.34 per month)

☐ I would like to contribute $ _____ for _____ year(s)

☐ OR one-time gift of $ _____

PLEASE SEE OVER FOR INFORMATION ABOUT OUR MONTHLY GIVING PROGRAM.

SINGLE PAYMENT OPTIONS

☐ I have enclosed my cheque of $ _____ made payable to ***The Ottawa Hospital Foundation***

OR

☐ Please charge my: ☐ VISA ☐ MASTERCARD ☐ AMERICAN EXPRESS

Cardholder's Name: _____

Card number: _____ Expiry Date: _____/_____

Signature: _____ Date: _____

☐ To make a secure on-line donation, please visit our website at www.ohfoundation.ca and click on "*Donate Now*". Please direct your donation to the "*Breast Health Centre*".

MG-BHC/DA
Breast Health Centre Expansion Fund - 500100

MONTHLY GIFT BY BANK ACCOUNT WITHDRAWAL OR CREDIT CARD CHARGE

Our monthly giving plan is an easy way to spread your generosity over the entire year. To join our monthly giving program, simply fill out the form below and the amount you choose will be automatically withdrawn from your bank account or charged to your credit card each month. You can stop your monthly donation or alter the amount of your gift at any time by contacting the office of The Ottawa Hospital Foundation at (613) 761-4295 or email foundation@ottawahospital.on.ca. You may also contact us by mail at 737 Parkdale Avenue, 1st floor, Ottawa, ON K1Y 1J8. To obtain a sample cancellation form, or for more information on your right to cancel your monthly agreement, you may contact your financial institution or visit www.cdnpay.ca. Thank you for your generosity.

☐ I authorize **The Ottawa Hospital Foundation** to make monthly bank withdrawals of $ _____
beginning the 1st of _____ and ending _____. My cheque marked VOID is enclosed.
month/year month/year

Name: _____ Telephone: _____

Signature: _____ Date: _____

☐ I authorize **The Ottawa Hospital Foundation** to make monthly credit card withdrawals of $ _____
beginning the 1st of _____ and ending _____.
month/year month/year

Please charge my donation to my: ☐ VISA ☐ MASTERCARD ☐ AMERICAN EXPRESS

Cardholder's Name: _____

Card number: _____ Expiry Date: _____/_____

Signature: _____ Date: _____

Please note that your monthly donation will be processed on the first business day of each month. You will receive a tax receipt for the full amount of your annual contribution at the end of the year.

I have certain recourse rights if any debit does not comply with this agreement. For example, I have the right to receive reimbursement for any debit that is not authorized or is not consistent with this pre-authorized debit (PAD) agreement. To obtain more information on my recourse rights, I may contact my financial institution or visit www.cdnpay.ca.

If you have any questions, please contact Jennifer Van Noort at 613-798-5555 ext 19498 or by e-mail at jvannoort@ottawahospital.on.ca OR Paula Street at 613-798-5555 ext 17418 or by e-mail at pstreet@ottawahospital.on.ca

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CHARITABLE REGISTRATION NUMBER: 86904 2747 RR0001

The Ottawa Hospital Foundation | La Fondation de l'Hôpital d'Ottawa

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