

This donation is made on behalf of

- an individual a business (please find my business card enclosed, tax receipt will be issued in the organization's name)

Company Name (if requiring corporate tax receipt) _____

Mr. Mrs. Ms. Dr. Other _____

First Name : _____ Last Name: _____

Address: _____

City: _____ Province : _____ Postal Code: _____

Home Phone: _____ Business Phone : _____

Email: _____

Yes! I will join my community and partner with the dedicated team at The Ottawa Hospital to save lives:

A My pledge will be: Monthly Annually

I am proud to pledge a gift of:

- \$1,200 per year for 5 years (\$100.00 per month)
 \$2,000 per year for 5 years (\$166.67 per month)
 \$5,000 per year for 5 years (\$416.67 per month)
 Other \$ _____ per month for _____ year(s)

OR

B I am proud to give a one-time gift of:

- \$1,200
 \$2,000
 \$5,000
 Other \$ _____

If you do not wish for your name to be listed as "First Name, Last Name", please select one of the below options:

- I wish to remain anonymous Other (please print) _____

PAYMENT INFORMATION

1. CREDIT CARD Corporate Card? Yes No

Please charge my / Veuillez porter à mon compte :

VISA M/C AMEX

Name on card: _____

Card number _____

Expiry Date _____ / _____

Monthly by Credit Card: Monthly gifts will be withdrawn on the 1st of every month

One-time gift as provided above

2. CHEQUE: I have enclosed my cheque made payable to "The Ottawa Hospital Foundation".

3. BANK DEBIT: Please include a void cheque. Will be withdrawn on the 1st of every month.

4. STOCK: Please contact me about paying my pledge with stock.

5. I would like more information about including a gift to The Ottawa Hospital in my Will.

6. I would like to receive receipt via email. / J'aimerais recevoir un reçu par courriel.

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.