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 year 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:

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☐ **Monthly by Credit Card:** Monthly gifts will be withdrawn on the 1st of every month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 Will be withdrawn on the 1st of every month.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

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.