



St. Paul's Hospital Foundation

1702 20th Street West

Saskatoon, Saskatchewan S7M 0Z9

Phone: (306) 655-5821 Fax: (306) 655-5825

Enclosed is my donation for: \$ _____

Cheque (payable to St. Paul's Hospital Foundation)

Visa #: _____

Mastercard #: _____

Expiry Date: _____

Signature: _____

Name: _____ Title (Mr., Mrs., Ms., Dr.): _____

Address: _____

City/Town: _____ Postal Code: _____

E-mail: _____ Phone: _____

For recognition purposes, I would like to be identified as: _____

Please send me information about Planned Giving

Please do not include my name in any Foundation Materials

Please send me information about donating via a pre-authorized payment plan

Specific area for donation:

Where the need is greatest Other: _____

I would like my gift made in honour or memory of: Name: _____

Address: _____

City/Town: _____ Province: _____ Postal Code: _____

Send acknowledgement to: Name: _____

Address: _____

City/Town: _____ Province: _____ Postal Code: _____

Send tax receipt to: Name: _____

Address: _____

City/Town: _____ Province: _____ Postal Code: _____