

Embracing THE Future

Enclosed is my donation for:

\$250 \$100 \$75 \$50 \$ _____

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

Pre-authorized Payment Plan (see reverse)

MasterCard # _____

VISA # _____

American Express # _____

Expiry Date _____

Signature _____

Name _____

Address _____

City/Town _____ Prov. _____ Postal Code _____

Phone _____

Email _____

Date _____

Please direct my donation toward:

Area of greatest need

Urology

MRI

Nuclear Medicine

St. Paul's Hospital Foundation Inc.

1702 – 20th Street West, Saskatoon SK S7M 0Z9

Phone: (306) 655-5821

Fax: (306) 655-5825

BN 11919 5691 RR0001

Donor Agreement for Pre-authorized Payment Plan

The undersigned hereby authorizes St. Paul's Hospital Foundation Inc. to draw funds from my chequing, savings or credit card account in the amount of \$ _____ per month by the 8th of each month. A charitable receipt will be issued once per year for pre-authorized payment donations.

First Name

Last Name

Address

City/Town

Prov.

Postal Code

Method of Pre-authorized Payment

Chequing account (please include a void cheque)

Savings account (please complete the following)

Name of Bank

Branch Number

Address of Bank

Account Number

Credit card (please complete the following)

MasterCard

VISA

American Express

Card Number

Expiry Date

This authorization may be cancelled at any time upon written notice. If you have any questions about this service, please call the foundation office at (306) 655-5821.

Signature _____

Date _____