PERTH & SMITHS FALLS DISTRICT HOSPITAL Foundation

Monthly Donation Form

Personal Information

Name: _____

Street Address: _____

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

Email: _____ Phone: _____

Donation Information

Monthly gift amount: ☐ $10 ☐ $25 ☐ $50 ☐ Other $_____

I prefer to give by: ☐Credit card (please fill out the **credit card** section below)
☐ Postdated cheques (to be made payable to the PSFDH Foundation)

Start Date (month/year): _____/_____

☐I understand that my donations will continue automatically each month until I notify the Perth and Smiths Falls District Hospital Foundation of any change. I can change or cancel my donation at any time.

Donations are processed at the end of each month. A tax receipt will be issued at the end of each giving cycle (1 calendar year) for all cumulative gifts given from January to December.

Credit Card

Card Type: ☐ Visa ☐ Mastercard

Card #: _____ Expiry (mm/yr): _____/_____

Name on card: _____ Security Code: _____

Signature: _____ Date: _____

Perth:
33 Drummond St. W
Perth ON K7H 2K1

PERTH & SMITHS FALLS DISTRICT HOSPITAL FOUNDATION

Smiths Falls:
60 Cornelia St. W
Smiths Falls ON K7A 2H9

343-881-GIVE (4483) or toll free 1-833-680-GIVE (4483)
Registered Charity Number 1192 36016 RR0001