



Victoria Hospital Foundation

Enriching the Heart of Northern Health Care

Monthly Giving Form

Donor Information:

Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Phone (day): _____ Phone (night): _____

Email: _____

I want to support the Victoria Hospital Foundation with a monthly gift of:

\$15 / month \$25 / month \$50 / month I prefer to give \$_____ / month

To: The Area of Greatest Need Other: _____

Payment Options (choose one):

A. I have faxed or enclosed a void cheque. I authorize Victoria Hospital Foundation to automatically withdraw the above amount from my account on the 1st of each month.

signature

date

B. On the 1st of each month, please charge my credit card in the above amount.

Visa Mastercard Amex

card number

expiry date

name on card

signature

date

I understand that donations will continue monthly until I notify Victoria Hospital Foundation of any changes. I may cancel my pledge at any time. I will receive an annual receipt for income tax purposes for the total amount of my monthly gifts.

The Victoria Hospital Foundation would like to acknowledge your generosity. If you wish to remain anonymous, please e-mail or phone the Foundation and we will ensure your name is not published.

Planned Giving:

- Please send me information about leaving a gift to the Victoria Hospital Foundation in my Will
 I have already left a gift to the Victoria Hospital Foundation in my Will.

Please mail form to:

Victoria Hospital Foundation
PO Box 3000 1200 24th Street W
Prince Albert, SK S6V 5T4

Fax form to:

(306) 765-6120

E-mail form to:

vhfoundation@paphr.sk.ca

Questions? Contact:

Suzanne Blain

(306)765-6105

vhfoundation@paphr.sk.ca

Charitable Registration No: 119285310RR0001.

Thank you for your support!