



Monthly Donation Form

Title: _____ First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone: _____ Email: _____

This monthly donation is made by: ☐ an Individual ☐ a Business _____
Company Name

Gift Amount:

Yes, I'd like to support St. Michael's Hospital Foundation with my monthly gift of \$ _____

Your donation will support the highest priority needs of the hospital. **Thank you!**

Payment Method:

☐ Cheque made payable to St. Michael's Hospital Foundation

☐ Please debit my bank account. My cheque marked VOID is enclosed.

☐ VISA ☐ MASTERCARD ☐ AMERICAN EXPRESS

Credit Card Information:

Credit Card Number: Expiry Date: /

Name on Card: _____

Email: _____

Signature: _____

☐ Yes, sign me up to receive e-newsletters.

Yes, I'd like to receive my tax receipt by email. _____

A consolidated tax receipt will be mailed in February for all monthly donations made in the previous calendar year.

Please return completed form via email to hello@stmichaelsfoundation.com, or mail to 30 Bond St, Toronto, ON M5B 1W8.

To make a donation by phone, please call 416 864 5000. Charitable Registration #122963663RR0001

Thank you for supporting St. Michael's Hospital Foundation.