ST. MICHAEL'S
HOSPITAL FOUNDATION

Research Innovation Council Membership Form

NAME

ADDRESS (number, street name)

CITY	PROVINCE	POSTAL CODE	PHONE: ☐ Home ☐ Cell ☐ Work

EMAIL

☐ One Lump Sum ($50,000) ☐ Over 2 years (2 x $25,000) ☐ Over 5 years (5 x $10,000)

PAYMENT METHOD:

☐ VISA

☐ MASTERCARD

☐ AMERICAN EXPRESS

☐ STOCK SHARES (see next page)

☐ CHEQUE (Payable to: St. Michael's Hospital Foundation)

☐ PAYROLL DEDUCTION

CREDIT CARD INFORMATION:

Credit Card Number:

Cardholder's Name:

Expiry Date: ___ / ___ CVV: ___

SIGNATURE:

DATE

HOW WOULD YOU LIKE TO RECEIVE FURTHER COMMUNICATIONS? ☐ EMAIL ☐ MAIL ☐ PHONE

Please email to **laura.yardeni@smh.ca**

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